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The continued support of the Media Division, Educational Programs Development Dept., Health Sciences Education & Training Command (HSETC), NNMC, Bethesda, Md., is gratefully acknowledged. Particular thanks for complete photographic coverage of the SAC and the Surgeon General's Conferences, are directed to the Medical Photography staff.

To all our readers, faithful contributors, and well-wishers, we extend warm greetings at this holiday season, and our sincere gratitude for your continued support over the past year.

CAUGHT IN A LIGHTER MOMENT.—During a luncheon at the Surgeon General's Conference, the Assistant Secretary of Defense (H&E), Dr. J.R. Cowan (3rd from the right) is flanked by a strong supporting cast. From left to right: RADM P. Kaufman, MC, USN; RADM R.G.W. Williams, Jr., MC, USN; RADM A.B. Duerk, NC, USN (our lady Admiral, behind the gladiolus?); RADM C.L. Waite, MC, USN; VADM D.L. Custis, MC, USN, the Surgeon General; and RADM D.P. Osborne, MC, USN, assistant chief for headquarters operations, BUMED Code 2.

from the Chief

Not long ago, I spoke to a large group of health care professionals from the Army, Navy, Air Force, Veterans Administration, and Public Health Service who were assembled in San Diego for the 81st Annual Meeting of the Association of Military Surgeons. I would like, in this month's column, to share my remarks with you.

"What a difference a year makes!

"We have completed our first year of adjustment to an all volunteer environment. We have finally acquired the last of the several major programs essential to our renewal. The protracted and frustrating struggle to achieve that program — the medical officer variable incentive pay — was a valuable lesson in realism, and a catalyst which brought together the diverse elements appreciative of the need for strength and quality in military medicine.

"That consortium also knows our struggle is not yet over; they are standing with us to defeat the relegation of service medicine to any restricted contingency role inviting mediocrity.

"Although we take satisfaction in our many programs calculated to deliver a good tomorrow, we are not so naive that we think they are immune to the vagaries of these times, be it inflation-inspired budget slashes on program support, or continued harrassment by our critics. Also, the fruition of military medical planning is always subject to the exigencies of new and unexpected threats to National security.

"It's time to take off the 'hair shirt' and face our detractors with the considerable counterforce at our disposal. No longer need we make abject

response to the ploy of 'when will we stop beating our wife.' The built-in waste of a draft driven professional service is gone. No longer will military medicine have such a costly turnover of indentured people, and their compromising influence on morale. No longer will we need to overtrain to stay ahead of the personnel turnstile. Even under such wasteful circumstances, we were more cost effective than was health care in the private sector. But now we will show such cost economy as to confound the most perverse of analysts.

"We have been analyzed, scrutinized and exorcised, yet we welcome further study. We know that Government must constantly make surveys to find out what the citizen gets for his money besides paying for the surveyors. But show me the analyst who won't let a problem stay solved, and I'll show you a man who is artifically justifying his job; his irresponsibility can no longer go unchallenged.

"Nor can we afford to spend further valuable time and money assisting those who would rediscover the wheel.

"I spent all last week witnessing the Board of Governors of the American College of Surgeons struggle with the perplexities besetting American medicine; and then I heard their guest speaker, Congressman Paul Rogers from Florida, deliver the message couched in properly differential terms, that if the medical profession doesn't straighten out this mess, Congress will.

"We've heard that message, too, and long ago accepted the challenge. We are the prototype corporate health care delivery system. We are the trailblazers in regionalization, whereas that effort in the civilian sector has largely failed. PSRO can be laid on us tomorrow without repercussion. We do not have surgery performed by the untrained. Our physician extender is sponsored and supervised. We have the answer, and will soon fill the void in primary care. Our academic and research prowess has only begun to grow. We have the management control to correct superspecialization and service fragmentation. Shortage of manpower remains a problem — maldistribution never was.

"Combat medicine and contingency logistics are our stock in trade. Where else lies that expertise?

"In short, we are at that point in time where self-doubt and expiation are no longer virtues. No health care system has labored harder for insight and innovation: none is more anxious to cooperate with all who would help us do our job. But let's get on with it."

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THE SURGEON GENERAL'S Sixth Annual SPECIALTIES ADVISORY CONFERENCE and COMMITTEES' MEETING

Moderator: CAPT Steve Barchet, MC, USN, BUMED Code 316.

This conference was held 16-20 Sep 1974 at Stouffer's National Center Inn, 2399 Jefferson Davis Highway, Arlington, Va.

The above account of this annual session represents an edited (sometimes paraphrased and/or abbreviated) version of the remarks and presentations of specified individuals. Their comments do not necessarily reflect official views of the Navy Department, or the naval service at large.

PROGRAM

Monday, 16 Sep 1974

1300: Registration
(Review of applicants may begin.)
1630-2200: Hospitality Suite Open

Tuesday, 17 Sep 1974 — First Plenary Session

0815-0830: Administrative Announcements
CAPT S. Barchet, MC, USN.
0830-0835: Welcoming Remarks
CAPT E.B. McMahon, MC, USN.
0835-0840: Welcoming Remarks
RADM E.J. Rupnik, MC, USN.
0840-0910: "Perspectives of the Navy Medical Department"
VADM D.L. Custis, MC, USN, Surgeon General.
0910-0945: "Training and Education Update"
CAPT W.M. McDermott, MC, USN.
1005-1045: "Health Care Services for the Navy and Marine Corps"
RADM C.L. Waite, MC, USN.
1045-1115: "Needs of the Navy Medical Department"
CAPT E.B. McMahon, MC, USN.
1115-1200: Panel Discussion
RADM E.J. Rupnik, MC, USN
RADM C.L. Waite, MC, USN
CAPT E.B. McMahon, MC, USN
CAPT W.M. McDermott, MC, USN
CAPT S. Barchet, MC, USN
(Moderator).
1200-1215: Instructions to Specialties Advisory Committee Conferees.
CAPT W.M. McDermott, MC, USN.
1300: Review of Applicants by Specialties Advisory Committees.
Appointments With:
CAPT S. Barcay, MC, USN, and
CAPT J.N. Trone, MC, USN.
1630-1800: Hospitality Suite Open
1800-1900: Cocktail Party
1900-2000: Banquet Dinner
2000-2100: "National Health Policy"
Malcolm C. Todd, M.D., Guest Speaker, President, American Medical Association.

Wednesday, 18 Sep 1974 — Second Plenary Session

0830-0915: "HSET Command — Functions, Activities, Responsibilities"
CAPT J.W. Cox, MC, USN.
0915-0945: Open Floor Discussion
1005-1020: "Medical Recruiting"
VADM Emmett H. Tidd, USN, Commander, Navy Recruiting Command.
1020-1045: "Evaluation in the Continuum of Medical Education: The GAP Report of the National Board of Medical Examiners"
William Mayer, M.D., dean, Columbia-Missouri School of Medicine.
1045-1055: "The Uniformed Services University of the Health Sciences"
CAPT M. Museles, MC, USN, executive secretary of the Uniformed Services University of the Health Sciences.
1055-1125: Anthony R. Curreri, M.D., president of the Uniformed Services University of the Health Sciences.
1300: Review of Applicants
Deliberation by Working Groups
Appointments With:
CAPT S. Barcay, MC, USN
CAPT J.N. Trone, MC, USN
G.H. Reifenstein, M.D.
CAPT D.T. Lansinger, MC, USN
CAPT E.B. McMahon, MC, USN
CAPT W.M. McDermott, MC, USN
CAPT S. Barchet, MC, USN.
1530-1630: "Rap Session with the Surgeon General"
VADM D.L. Custis, MC, USN.
Moderator: CAPT J.W. Cox, MC, USN.
1630-2000: Hospitality Suite Open

Thursday, 19 Sep 1974

0800-1200: Review of Applicants
Appointments With:
CAPT S. Barcay, MC, USN
CAPT J.N. Trone, MC, USN
CAPT W.M. McDermott, MC, USN
CAPT S. Barchet, MC, USN.
1200: Begin Collation of Slates

1300-1630: Continue Collation of Slates
Compilation of Major/Minor Proposals and Recommendations.
1630-2000: Hospitality Suite Open

Friday, 20 Sep 1974 — Third Plenary Session

0800-0930: Presentation of Major Recommendations/Issues/Proposals.
Moderators:
RADM-select D. Earl Brown, MC, USN, and CAPT S. Barchet, MC, USN.
Discussion of Each by Surgeon General and Support.
0945-1045: Presentation of Dissenting or Minority Recommendations/Proposals/Issues.
Moderators and Discussion, as above.
1045-1100: Summation of Sixth Annual SAC
CAPT J.W. Cox, MC, USN.
1100: Adjournment

SAC CHAIRMEN

Anesthesiology:
CAPT Richard H. Norton, MC, USN, Portsmouth, Va.

Dermatology:
CAPT Bernett L. Johnson, Jr., MC, USN, Philadelphia.

Family Practice:
CDR Robert W. Higgins, MC, USNR, Charleston.

Hematology/Oncology:
CAPT Jesse E. Lang, MC, USN, San Diego.

Internal Medicine:
CAPT James W. Lea, Jr., MC, USN, Portsmouth, Va.

Obstetrics/Gynecology:
CAPT Douglas R. Knab, MC, USN, NNMC Bethesda.

Ophthalmology:
CAPT Lewis H. Seaton, MC, USN, NNMC Bethesda.

Orthopedic Surgery:
CAPT Charles S. Lambdin, MC, USN, Portsmouth, Va.

Otolaryngology:
CDR Fred J. Stucker, MC, USN, Philadelphia.

Pathology:
CAPT Nicholas A. D'Amato, MC, USN, Portsmouth, Va.

Pediatrics:
CAPT William M. Bason, MC, USN, Philadelphia.

Psychiatry:
CAPT Rolf W. Steyn, MC, USN, Oakland.

Radiology:
CAPT Quintous E. Crews, Jr., MC, USN, San Diego.

Surgery:
CAPT Stephen J. Mucha, MC, USN, Philadelphia.

Urology:
CAPT Gilbert A. LeBlanc, MC, USN, Oakland.

Internship:
CAPT Robert J. Van Houten, MC, USN, NNMC Bethesda.

Oral Surgery:
CAPT T.W. McKean, DC, USN, Oakland.

Operating Forces:
RADM C.L. Waite, MC, USN, BUMED Code 5.

Research & Development:
CAPT C.E. Brodine, MC, USN, CO of the Navy Medical Research and Development Command, Bethesda.

DIRECTORS OF CLINICAL SERVICES

NNMC Bethesda:
RADM-select D. Earl Brown, Jr., MC, USN, chairman

Camp Pendleton:
CAPT Jean-Jacques Gunning, MC, USN

Charleston:
CAPT Clinton H. Lowery, MC, USN

Great Lakes:
CAPT William J. Wagner, MC, USN

Jacksonville:
CAPT Alton L. Powell III, MC, USN

Oakland:
CAPT George E. Gorsuch, MC, USN

Pensacola:
CAPT Paul Gregg, MC, USN

Philadelphia:
CAPT Robert L. Mullin, MC, USN

Portsmouth, Va.:
CAPT Norman G. Lewis, MC, USN

San Diego:
CAPT Roger F. Milnes, MC, USN

FIRST PLENARY SESSION, 17 SEP 1974

Administrative Announcements — CAPT S. Barchet, MC, USN:

Admiral Custis, Dr. Curreri, our distinguished flag officers, guests, and to all of you, welcome to the annual convening of the Surgeon General's Specialties Advisory Conference and Committee Meeting.

This meeting has attained immense importance, thanks to you, and preparation for this year's meeting has been ongoing for some months, at times in the manner of a Grecian dithyrambic frenzy. For those of you who are charter members of the Specialties Advisory Committees (SAC), there are some obvious differences and some which are a little more subtle. The major purposes, aims and objectives of the SAC remain inviolate. However, a few variations on the theme bear notice:

1) A modest paper package — a sign of austere times — has been issued to you in lieu of a richly tooled, embossed, and well appointed SAC folder. The substitution provided sufficient funds to send 2 GMOs to a meeting.

2) Program changes. The Surgeon General will address "Perspectives of the Navy Medical Department," and RADM Waite will discuss "Primary/Health Care Services for the Navy and the Marine Corps."

3) To lengthen your time for work and deliberation, only 3 morning plenary sessions are offered which will enlighten us on the present status and future needs of physician education.

4) The Surgeon General's Rap Session will start at 1530 tomorrow. Written questions may be submitted, with total anonymity if desired. *(Directions given)*

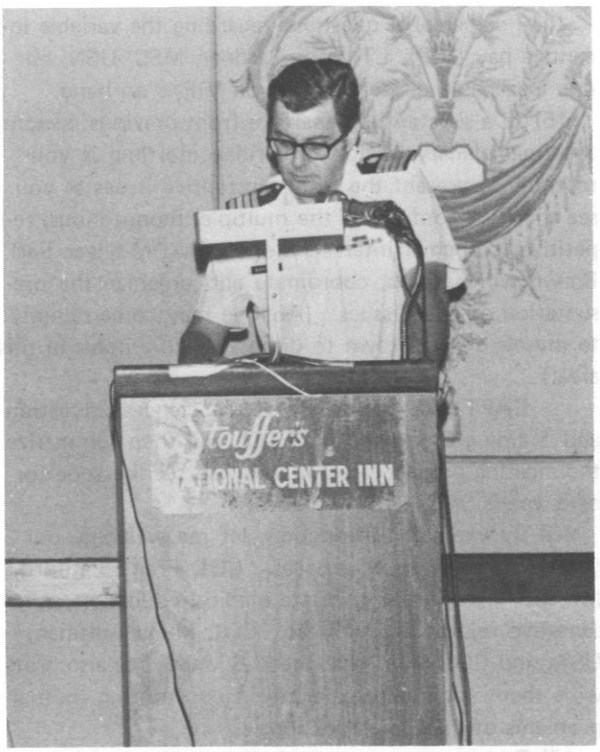
5) We have employed a verbatim recorder in order to provide published reports and proceedings of the SAC meeting in the future.

6) For the first time, guidelines and objectives for both the Intern Program directors and SAC participants have been published and distributed well in advance of the meeting. (Extra copies are available at the Registration Desk.)

7) Another innovation — considerations of medical student and physician applications have been joined as closely as possible in one meeting, within the sense of the integration of internships.

8) Reprints of timely articles that should interest you are available at the Registration Desk. One of them is entitled "Congress Is Looking at You," and they *are* looking, of that you can be assured.

9) Two new groups have joined the SAC as "voting members." We welcome their participation — the oral surgeons, and the senior representatives and advocates for the operating forces.



SAC SIX, OFF AND RUNNING.—Moderator for the conference, CAPT Steve Barchet, MC, USN (Head, Training Branch, BUMED Code 316), opens the 1st plenary session with some administrative announcements.

10) The Internal Medicine group has been subdivided to allow the subspecialties to gather separately. However, this group has the largest number of applicants ever, and flexible arrangements for dealing with the record number of candidates will be required.

11) This year, the senior ranking specialist is not necessarily the chairman, major coordinator, and spokesman for his committee. In order to broaden experiences and infuse an expansion of responsibility, each group will henceforth elect the future chairman who will serve at the next SAC meeting.

12) The annual banquet has been rescheduled for Tuesday night to accommodate our guest speaker, Dr. Malcolm Todd, President of the American Medical Association.

13) Improved arrangements for private appointments with key officials and representatives can be made in the Executive Suite, Room 1100. (Those available include: CAPTs Trone, Barcay, and others; Dr. Reifenstein, CIP director; CAPT Don Lansinger, our master builder; and LT Ken Shaffer, MSC, USN, deputy director of the Hospital Corps Division.)

14) For personal questions regarding the variable incentive pay (VIP), LT Jerry Gardner, MSC, USN, our unimpeachable resident expert on VIP is on hand.

15) In a substantial departure from previous custom, the final plenary session on Friday morning is your morning to present the true, substantive issues as you see them, in contrast to the multiple, monotonous, repetitive, parochial interests alone. RADM-select Earl Brown will develop, coordinate and organize the presentation of these issues. (Anyone may come directly to myself or Dr. Brown to discuss specific items in this area.)

CAPT J.W. Cox, CO, Health Sciences Education and Training Command (HSETC), will then summarize the meeting proceedings and will also set the tone for next year's SAC.

16) By way of introduction, let me welcome our guests from the sister services. COL Frank Ledford, MC, USA, the Army graduate medical education representative rejoins us this year. COL Mims Aultman, USA, and COL Snyder of the U.S. Air Force also bring with them admirable expertise in confronting mutual problems of medical education.

17) Do not expect too much from hallway and curbstone consultations, particularly if major commitments of dollars, billets, personnel and other resources are involved.

18) Each written report of each specialty committee is a valued document of considerable importance to you and to the Bureau, but it does *not* constitute a legitimate substitute for a properly submitted official command channel request to BUMED.

19) CAPT Bill McDermott, MC, USN, assistant head of the Training Branch (BUMED Code 316-1), will provide detailed administrative charges and announcements later this morning. We have a heavy schedule, and there are 520 records to evaluate.

20) In the interest of enhancing communications and participation in BUMED education/training policies, I hope that the directors of clinical services and the Intern Program directors may be invited to gather for a halfway-house conference in March 1975.

Welcoming Remarks —
*CAPT E.B. McMahon, MC, USN:**

It is a pleasure to welcome all of you to the 1974 SAC. Everyone in the Professional Division, BUMED Code 31, will be available to assist you in any way that we can during the time you are here. In your schedules you will note that times have been set aside for specific appointments with the detailers. If the allotted time is insufficient, we'll make more available. If you have any problem with this at all, please contact me personally.

Welcoming Remarks —
*RADM E.J. Rupnik, MC, USN:***

I wish to extend to all of you a hearty and warm welcome to this 6th Annual Surgeon General's Specialty Advisory Conference and Committee Meeting (SAC). It gives me much personal pleasure and pride to see so many of our outstanding leaders in graduate medical education, gathered here to work toward a cohesive common purpose — preparing the professionals who will provide health care for the Navy, and the Navy's beneficiaries.

Reflecting back a few years, I would like to relate some of the historic, dynamic evolution of these SAC conferences. Such an annual meeting was conceived in the Bureau following 2 BUMED workshops on medical education, organized and chaired by Dr. Reifenstein, and held in 1967 and 1969. Chiefs of service from graduate-training hospitals assembled at the initial SAC meeting in Sep-Oct 1969, to assist in selection of applicants for residency training programs and to discuss problem areas in depth.

Surprisingly, prior to that time, chiefs of teaching services had no voice or direct participation in the selection of their residents.

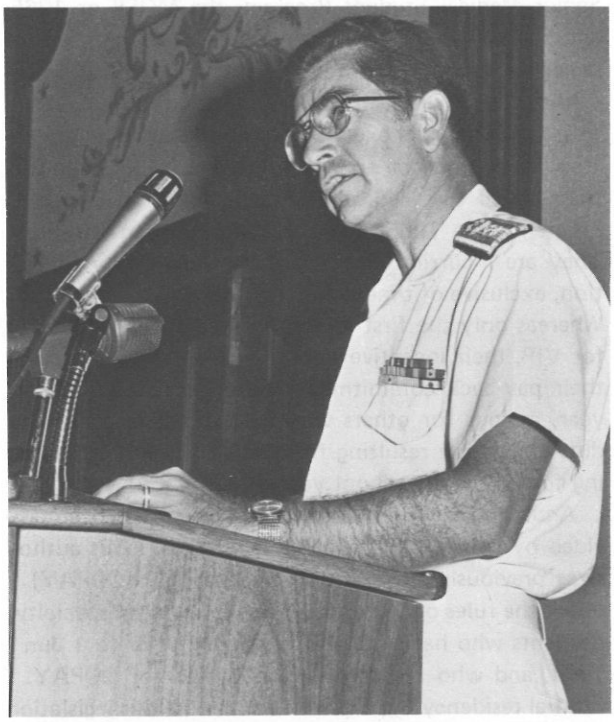
In that initial SAC meeting, 15 specialty groups met for 1-day sessions only, each on a different day. This placed a tremendous administrative burden on all BUMED personnel, especially Code 316. As head of the Training Branch at the time, I acquired authorization for extension of the group meetings to 2 full days, with each assembly to be comprised of 30 representatives.

Some 90 chiefs of service attended the 2nd Annual SAC, again severely limited by time; 486 applicant records were reviewed and graded within 3 hours. One and a quarter hours were allotted for discussion of problems, and written recommendations for solutions. Despite these constrictions, the sense of the 2nd conference was a resounding success and a pattern for future meetings evolved. VADM Davis and RADM Norris approved and supported plans for the 3rd SAC.

On the basis of past experiences, I outlined the following recommendations for SAC Three, to be held in the fall of 1971: 1) a 4-5 day conference; 2) a single,

*Director of the Professional Division, BUMED Code 31.

**Assistant Chief for Personnel and Professional Operations, BUMED Code 3.



WELCOME.—RADM E.J. Rupnik, MC, USN reflects on the historic evolution of SAC and charges conferees to work toward a cohesive, common purpose.

annual gathering of our leading educators; 3) a worthy conference site; 4) plenary sessions, designed to impart and receive information; 5) sufficient time for interaction between attendees and the BUMED detail section; 6) sufficient time for informal interchange; 7) sufficient time to develop the problems, issues, recommendations and solutions, and; 8) sufficient time to evaluate the applicants.

Though only peripherally involved with the 3rd, 4th, 5th, and now the 6th SAC, I can perceive that the major purposes and objectives of this annual conference have not only been preserved, but have also been strengthened. This historical review serves to illustrate the philosophy expressed by Elliot Richardson in the Shattuck Lecture before the Massachusetts Medical Society,* which CAPT Barchet called to my attention:

"It is more necessary than ever that we seek some sensible approach to change, preserving some continuity, some sense of proportion, some appreciation of the old order so fast yielding place to the new, for without an appreciative sense of the old, we cannot properly measure, we cannot sensibly evaluate, we cannot discriminately reject or affirm the new."

*Richardson EL: "The old order changeth, yielding place to new": Perspectives on the health "revolution." *N Engl J Med* 291(6):283-287, 8 Aug 1974.

"Perspectives of the Navy Medical Department" — VADM D.L. Custis, MC, USN, the Navy Surgeon General and keynote speaker:

Gentlemen and gentlewomen, I'm pleased and proud to welcome you to the 6th Annual SAC Conference — pleased that you are gathered together once more to address the issues, and help formulate the hallmark of tomorrow's Navy medicine. I take pride not only in the accomplishments of you, our teachers, but in the knowledge that individually and collectively, you care enough to do your very best.

This is the 2nd time as Surgeon General that I have had the opportunity to address the SAC Conference, and I hope my performance this time proves better than that attested to in the story of a new minister who, along with his new bride, arrived in a town to take over a new parish. In an effort to help initiate him, the local Rotary Club invited him to address them on the subject of sex. The minister accepted. The next day, his bride heard about the invitation and she asked him what he was going to talk about. He faltered, "Er, um, I'm going to speak about, uh, sailing." Noting his discomfiture, she let it go at that.

Several days later she encountered a Rotarian who thought he knew her well enough to have a little fun. And so he said, "You should have heard your husband's talk at the Rotary. He was tremendous. You would have been so proud. He really knew his subject."

She was incredulous. She replied, "Well, that's strange. He only tried it twice before he quit. The first time, he got sick; and the second time, he capsized."

There is so much I want to tell you because you, the clinical chiefs and the teachers, more so than any other community are the hope of tomorrow's Navy medical system.

Let me start with an admonition: never underestimate yourselves. The responsibility you carry is tremendous. You set the climate for, and the caliber of patient care. The young professionals, the interns and residents in your charge number two thirds of our career and potential-career, medical and dental officers. Their concern for their patients, their professional curiosity and development, their attitude and enthusiasm for Navy medicine, and their identity with the Navy itself are largely functions of your guidance, and products of your example. I know you have their respect, no less than you have mine. My own conviction for a good tomorrow is heavily rooted in my satisfaction that you are out there today.

This morning I would like to address just 2 perspectives, along with some of their implications: 1) the

long awaited and recently implemented variable incentive pay (VIP) for medical officers, and; 2) the developing impact of HR-2. There are many other perspectives worked into your meeting agenda, as well as an opportunity for me to join you later in a dialogue on subjects of your choice.

I won't burden you with a recap of the arduous birth of the VIP bill. That exposé is the subject of this month's "From the Chief" column in *U.S. Navy Medicine.* It has been a very revealing experience. The point is, we now have an incentive pay program which, although it comprises not all of what we wanted, will work. It provides sufficient compensatory resource, not to equate, but at least to compete with the civilian market for that high-priced commodity, the physician. The emphasis that I give this VIP legislation is not to imply that it alone will assure our renewal; I wish only to highlight its features.

We have requested authorization for making any given contract retroactive to 5 Sep 1974, the date of the final Presidential signature.*

VIP will authorize qualified medical officers, in our case already notified of selection by Board action, in pay grades of 0-3 through 0-6 and who are not serving in intern or initial residency training, a bonus of up to $13,500 a year for each year of active duty served after completing initial active-duty obligation, by contract agreement.** The maximum bonus will be reserved for young physicians (the most difficult to recruit and retain) who will extend for a 4-year period. The bonus is reduced incrementally by year for shorter agreements, to $12,000 for a 1-year contract; it also decreases with longevity, declining to $10,000 for a 1-year agreement by a CAPT with more than 26 years of service; in the latter case the bonus may be increased to $11,000 a year for a 4-year contract.

Disqualifying active duty obligations are those derived from prior participation in the Berry Plan, the Senior Medical Student Program, the MOSP or 1965, and the HR-2 or 1975 programs. For the purpose of participating in VIP, in no case will disqualification because of active duty obligation extend beyond 4 years.

There are several exceptions and caveats to be understood as regards the trainee. The first involves the participants of the Medical School Scholarship Subsidy Programs, the 1965- and the 1975-Program enrollees. They are incurring up to 7 years' active duty obligation, exclusive of time spent in postgraduate education. Whereas only the first 4 of those years is disqualifying for VIP, their incentive pay throughout the balance of their pay-back commitment is limited to $9,000 per year, as it is for others who are serving in an active-duty obligation resulting from any Navy-funded training for 1 or more school years.

Another exception for certain trainees has been provided by companion Save Pay legislation. This authorizes previously defined continuation pay (COPAY) under the rules of VIP to all primary or initial specialty residents who had entered active duty prior to 1 Jun 1974, and who are otherwise qualified for COPAY. "Initial residency" is a term specified in this legislation and construed to cover that period of time in residency training prior to formal completion of the officer's first residency.†

Subspecialty training — for example, a fellowship beyond Board eligibility in the primary specialty — will not otherwise disqualify an active duty member already receiving VIP. A flight surgeon with several years' active duty and on VIP, as an example, will revert to COPAY if he starts an initial or primary residency. But if he is already certified or qualified in a primary specialty, he can enter into secondary fellowship in a subspecialty without discontinuing his VIP.

The law also contains a conversion clause so that officers receiving COPAY, who are otherwise eligible to receive VIP, may repay the unearned amount of COPAY and thereby become immediately eligible for VIP; and that applies, I suppose, to most people in this room. (Of course, dental officers and all flag officers remain eligible for COPAY.)

Unlike COPAY, VIP has an escape clause for voluntary cancellation of contract with, however, penalty pay reduction. Coincidentally there is a provision for an increase in professional pay, from $100 to $350 a month, upon completion of 2 years of active duty.

Finally, it should be remembered that COPAY will continue to be affected by base-pay raises, while VIP figures are fixed and not subject to pay raises.

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*As it subsequently developed, this authorization has not been granted by the DOD Counsel General.—Ed.

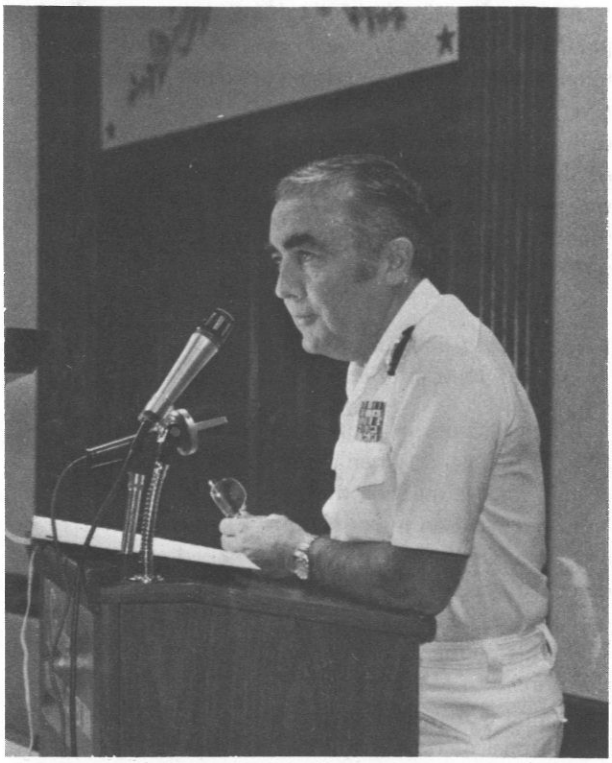
**For legislation and applicable directives, readers are referred to the following:

VIP: PL 93-274.
DOD Directive 1340.11 of 12 Sep 1974.
ALNAV 87 — SECNAV MSG 302245Z Sep 1974.
SECNAVINST 7220 series, in press.

COPAY: PL 93-394 (for officers already in or who entered initial RESTRA on active duty 1 Jun 1974).
DOD Directive 1340.8 of 16 Sep 1974.
SECNAVINST 7220.61B, and 7220.61C, in press.
ALNAV 91 — SECNAV MSG 041548Z Oct 1974.

LT G.L. Gardner, MSC, USN — BUMED Code 317A.
Telephone Autovon: 294-4288
(Commercial 202: 254-4288).

†First residency is a period of training that leads to Board eligibility for certification by the AMA.—Ed.



SURGEON GENERAL VADM D.L. CUSTIS, MC, USN.— "We have many programs calculated to deliver a grand tomorrow, but none of our perspectives are immune to the vagaries of time."

Translated into an illustrative hypothetical full career pay curve, the medical officer entering active duty at the rank of LT, without service obligation and electing full VIP options, will have an initial annual income of over $34,000; and he will reach $47,000-plus, in constant 1974 dollars, when he becomes a senior CAPT. If the current ceiling on base pay is elevated, as it is expected to be, the maximum income for an 0-8 will be over $52,000 a year.

So much for statistics. Consider a few of the implications. With these new pay scales, with Congressional pressure on us for maximal utilization of military physicians, and with a flood of protests from dependent beneficiaries who are witnessing cutbacks on our health-care-service provision, it is inevitable that the subject of moonlighting is receiving critical review at the headquarters level of all three military medical departments. I ask you to consider the subject of moonlighting during your deliberations this week. I shall not influence you at this time with my own specific notions on moonlighting, except to say that provisions for it should, must, and will be tightened.

In my visits to your hospitals, I have discussed with many of you the pros and cons of the Clinical Admiral Program. Last month, the Chief of Naval Operations signed an order for its official discontinuance. I have delayed the general announcement pending this opportunity to discuss the circumstances with all of you who are primarily involved.

The program, as you know, was conceived 3 years ago as one modality for providing added career incentive. A clause requesting an additional 15 flag billets for the Navy alone — medical flag billets, that is — was made a part of HR-2. The request did not survive preliminary hearings by the Congress. In spite of this, ADM Zumwalt (then CNO) authorized 1 billet per year to launch the program on a trial basis. This past July, those 2 extra billets given for Clinical Admirals were ordered returned to the line, as a part of an overall reduction in flag strength. We were by that time willing to concede failure of the program as one which, because of its extremely limiting restraints, created more problems than it solved.

And now, with the rapid advent of the Uniformed Services University of the Health Sciences (USUHS), senior faculty appointments will soon provide the most meaningful recognition for outstanding clinical, teaching, and research talent. With their concurrence, RADMs Baker and Jacoby will next year receive executive medical assignments along with the regular flag community.

This introduces the subject of executive medicine, a program of which you are already informed. Let me say once more that no medical or dental officer will be assigned outside of a clinical pursuit unless he so desires. We are reducing our nonclinical executive billets to a level not to exceed 1.5% of the Medical and Dental Corps strengths. We also mean to do all that we can to optimally provide management training for the qualification of those who are headed for senior staff and command assignments, regardless of their corps origin.

To this end we have just now instituted a Command Selection Board, patterned after the precepts of a program long since in operation for the line.* The Command Selection Board system will, in our case, provide the opportunity at the proper career stage for senior officers in all corps to declare their interest in executive medicine — and here I use the term "medicine" in its broad sense. The Command Selection Board will then have the responsibility, not to comparatively grade those best qualified, but to eliminate those who are not to be considered qualified for top management and executive leadership roles, on the basis of their records.

*The reader is referred to page 35 of the October issue of *U.S. Navy Medicine.*

Within this system there shall be no implied assurance, nor assumption of receiving any specific set of orders. In short it is an opportunity for declaration of intent, and then submission to a plucking process.

A year ago, I mailed to each member of SAC a copy of a paper I had written entitled, "Education, Training, and Research, the Lifeblood of Military Medicine." In it, I outlined my view that HR-2, and specifically the USUHS, is a propitious and an essential element in our renewal. I went on to specify what we could expect from the University, and I predicted the general course of its development and impact.

More recently certain anxieties have been voiced by some of you, that there may be unwanted incursions into service training prerogatives. After serving this past year on the Board of Regents, I want to tell you that I have encountered no cause for such anxiety. On the contrary, the same expectations I expressed last year are not only valid today, but the progress of the school exceeds all expectations. Dr. Curreri, who is with us this morning and who will address you tomorrow, has eminently proved to be the right man for the right job at the right time. Certainly, there will be a new impact on our educational training and research environment. There will be integration, and there will be adjustment; but this University will be for you to shape, every bit as much as it reshapes our own profile.

If there is among you a chronic worrier who must feed his compulsion, let him look to the newly proposed Kennedy-Javits legislation on health-care manpower which John Cooper, the director of AAMC, tells me has an excellent chance of passage. Under it, any medical school receiving Federal subsidy — and what school does not? — must have 100% agreement from its students to serve for 2 years in a health-care-deprived area. Tuition grants to any individual student will carry 4-year obligations for such service. And we thought the doctors' draft had ended.

HEW will be charged with certification of all residency programs, limiting specialty-training opportunity in accordance with HEW's evaluation of national need. Also, Federal control of state medical licensure and 6-year relicensure will be vested in HEW.

We have many programs calculated to deliver a grand tomorrow, but none of our perspectives are immune to the vagaries of time. Right now, a sick national economy is inspiring FY-75 budget slashes on the very programs that are essential to an all-volunteer-force success. A national health bill will most certainly redound on military medicine. Although we're tracking it and have no lingering doubt of its direction, and although we've readied our defense, we have yet to feel the buffeting of the OMB storm.

And finally, the fruition of any military medical planning is subject to the exigencies of any new and unexpected threat to national security. While a full review of our perspectives provides ample reason for confidence and optimism, it underscores the validity of that prayer which solicits the serenity to accept the things we cannot change, the courage to change the things we can, and the wisdom to know the difference.

"Training and Education Update" —
*CAPT W.M. McDermott, MC, USN:**

Admiral Osborne, Admiral Rupnik, distinguished flags, gentlemen. When Steve and I developed the agenda for the meeting this morning, we decided that I did not need an introduction. Exactly 1 short year ago I sat out there with you, and asked as I know you do each day, "What are those dumb birds at the Bureau going to do next?"

At this point, I am going to tell you. In working at the Bureau of Medicine and Surgery one has to learn, in dealing with you and with our internal bureaucracy, a great deal of flexibility. I would just like to lead off my remarks with a short story emphasizing this particular feature. There was a young Chinese engineer who was called before the grand tribunal in the People's Republic of China and given a massive project. He was told, "Young man, in the western part of our country there is a massive mountain which requires the digging of a tunnel. We want you to go out to it, study it, and then come back and tell us how to solve this problem."

The young man went west and studied, surveyed, measured, dug, finally returned to the grand tribunal of graybeards, and said: "Reverend gentlemen, I have solved it. I'm going to put one huge number of coolies on one side of the mountain, and then I'm going to put another huge number of coolies on the other side of the mountain; and I'm going to tell them to start digging."

One old graybeard stroked his chin and said, "Young man, that's an eminently great plan. However, what if they're not opposite each other?"

And the young man said, "Graybeards, I have solved that, too. If they are opposite each other, we will have one tunnel. If they are not, we will have two."

In the next 30 minutes I plan to present a vast amount of material which will highlight perspectives of our education and training effort at this particular point in time.

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*Assistant Head, Training Branch, BUMED Code 316-1.

"DR. APPENDIX."—CAPT W.M. McDermott, MC, USN, delivers a talk on "Training and Education Update," pregnant with vital statistics. (See Appendix)

At the end of the last fiscal year, approximately 24.8% of the total Medical Corps strength was in a training status, including around 155 interns. In the present fiscal year, again, just under 25% of the total Medical Corps strength is in a training status, including about 185 interns.

A total of 223 residents have completed residency programs this year; a breakdown of their specialties or subspecialties is presented in Table 1. (See Appendix, Table 1)

Of the 238 selected residents for FY-75, 86 had completed Naval internship, 119 came from the fleet or active duty forces, and 33 entered from the civilian community. (See Appendix, Table 2)

Let's consider the positions that these selected residents will occupy. By separate institution, 91 different hospital programs are involved. Twenty separate residency categories (specialty/subspecialty) and 14 fellowship programs are represented. (See Appendix, Table 3)

As of 30 Jun 1974, 662 medical officers were assigned as residents to approved services of naval medical institutions.

Directing your attention now to the distribution of selected interns placed throughout our naval hospitals for the academic 1974-1975 year, it should be noted that a group of late graduates have been placed into the system. With only 1 or 2 exceptions, these additions will be charged to the academic 1974-1975 year. (See Appendix, Table 4)

Within the same time frame, let's address our out-service commitments. A total of 24 physicians completed out-service training programs in 1974, and 13 will emerge this coming year. For breakdown by specialty, see Table 5. (See Appendix, Table 5) A total of 23 physicians occupied residency positions in civilian institutions or out-service programs this year. (See Appendix, Table 6)

In the development of in-service training programs, we have made further strides. This year we have initiated the following new residencies and fellowships:

Anesthesiology Research — NNMC, Bethesda
Dermatology — NNMC, Bethesda
Family Practice — NRMC, Charleston
Gynecologic Endocrinology — NRMC, Oakland
Nephrology — NRMC, Portsmouth, Va.
Nuclear Medicine — NNMC, Bethesda
Peripheral Vascular Surgery — NRMC, San Diego
Surgical Research — NNMC, Bethesda
Nuclear Medicine — NRMC, Oakland

In many cases, these programs have been on the drawing board for 3-4 years before requirements were firmly established to authorize their introduction. There is a strong impetus to increase our number of Family Practice specialists; in 1974 12 such specialists graduated from Naval training programs, and we anticipate 21 more graduates in 1975.

There is also a continued thrust to increase and strengthen umbrella agreements with the large training and multispecialty graduate hospitals, as well as the hospitals with family practice programs. Several new umbrella agreements have been developed this year, the latest being a memorandum of understanding between Oakland and the University of California (San Francisco), now ready for implementation. All of our larger multi-specialty training hospitals are actively involved in such arrangements, and the hospitals with family practice programs are rapidly following suit.

In the continuing medical education area, there has been considerable expansion that reflects our heightened interest and mutual efforts. (See Figure 1) BUMED is allocating funds to increase naval participation and tri-service programs in the form of participants, lecturers, panelists, and attendees. Financial constraints have been felt here, as elsewhere. But during 1974 in support

FIGURE 1

CONTINUING MEDICAL EDUCATION

A. Annual AMA-Approved Programs:

1) SAC, 9/16/74 - 9/20/74, Washington, D.C.
2) Annual Pediatric Visiting Professor Symposium, 9/14/74 - 9/30/74, NNMC, Bethesda, Md.
3) Visiting Professor Symposium Neurosurgery, 9/20/74 - 9/21/74 and quarterly, NNMC, Bethesda, Md.
4) Washington Blood Club Meeting, 5/6/74, NNMC, Bethesda, Md.
5) Management of the Acute Critically Ill Patients, 10/74, NNMC, Bethesda, Md.
6) Pathology Symposium, Spring/75, NNMC, Bethesda, Md.
7) Radioisotope Techniques and Nuclear Medicine, 9/16/74 - 11/8/74; 3/3/75 - 4/25/75; NNMC, Bethesda, Md.
8) Core Curriculum in Echocardiography, 6/6/74 - 6/8/74, Naval Hospital, San Diego, Calif.
9) Clinical Advances in Shock and Trauma, 3/75, Naval Hospital, San Diego, Calif.
10) Executive Medicine, triannually, NNMC, Bethesda, Md.
11) Anesthesiology Symposium, 9/5/74 - 9/7/74, Naval Hospital, Portsmouth, Va.
12) Macklin Memorial Series, 11/8/74, Naval Hospital, Portsmouth, Va.
13) Spring Trauma Symposium, 3/75, Naval Hospital, Portsmouth, Va.

B. BUMED Supported Triservice Programs:

1) AF District meeting, ACOG, annually; 1974 — NNMC, Bethesda, Md.
2) Triservice Pediatric Seminar, annually, NNMC, Bethesda, Md.
3) Triservice AF Chapter of AAFP, annually; 1974 — Andrews AFB.
4) Triservice Orthopedic Symposium, annually; 1973 — Portsmouth, Va.
5) PA Preceptor Meeting, annually, Sheppard AFB.
6) Society of AF Medical Laboratory Specialists, annually; 1974 — New Orleans, La.

of integral parts, short courses, and the like, which are regarded as the lifeblood of our programs, we have been able to allocate $350,000 for travel and $80,000 for fees. In FY-1975, in support of integral-part training, we anticipate spending in the neighborhood of $472,000 for travel and $100,000 for fees. While it is recognized that hospitals lack adequate funds to permit all the travel desired for meeting attendance, it is evident that BUMED is making substantive effort to allocate money for conference travel by direct funding to the hospitals. In addition to the direct support of integral-part training, BUMED Codes 3 and 31 have contributed well in excess of $8,000 in support of the Visiting Chiefs Program, which has been very active throughout the past year and has been utilized by many of you.

One of the principal assets to which we look for a rejuvenation of our Medical Corps, and which will represent a principal source of recruitment, is the **HR-2 Public Law 92-426 program.** At an annual cost of from $7,000 to $10,000 per student, we presently claim a total of 1057 participating medical students. (See Appendix, Table 7) There are 250 people participating in the **Medical and Osteopathic Student Scholarship Program (MOSP),** an active duty program which costs in the neighborhood of $15,000 to $17,000 per student per year. Another active-duty extension of the 1915 program, the **Senior Medical Student Program (SMSP)** entitles participants to pay and allowances for the senior year, but tuition costs are borne by the students. The SMSP represents but a very small portion of our overall programs and provides selected students the pay and allowance of a LTJG, commensurate with his years of service.

We are depending heavily upon the 1975 (HR-2) Program as a future source of Medical Corps officers. (See Appendix, Table 8) A very small number of 1915-Program participants, on no subsidy program, represents a group of medical students who have allied themselves with the Navy early in the game, with the intention of participating in Naval training at a later date.

In response to the increased demand for medical personnel, the Nurse Corps has been very active in developing training programs which prepare selected nurses to deliver health care services. (See Appendix, Table 9) With the cooperation and support of BUMED Code 31, the Nurse Corps is administering programs for training and placement of nurse practitioners in the following areas: pediatrics, OB/GYN, family practice, and midwifery.

In a similar manner, selected corpsmen are undergoing specific training and placement in designated billets in the Physician Assistants (PA) program. In this

FIGURE 2

GUIDELINES FROM THE COUNCIL ON MEDICAL EDUCATION

1. "Freestanding" internships will not be approved after 30 Jun 1975.

2. First graduate year of medical education must be in the continuum of medical education.

3. First year of medical education following the receipt of the M.D. degree must be accredited by an appropriate residency review committee.

4. The first-year graduate medical education program for which a graduating medical student applies must be approved by the director of a certified residency program in the appropriate specialty.

5. The term "internship" will remain as long as necessary to insure licensure capability in the various states of the U.S.

6. Definition of Programs:

A. Categorical — supervised by one discipline and designed to prepare the individual for a specific specialty. Program content must be acceptable to the respective specialty board as part of the graduate training in the specialty. Applicant must reapply for continued training; unless he has signed a MOST (medical officer's service training) agreement.

B. Categorical Diversified — multidisciplinary program in which the major program content (6-8 months) is related to the specialty but also has diversification in total content — can be acceptable to several specialties.

C. Flexible — program content is acceptable to 2 or more specialty boards. Program must include 4 months of medicine and other educational experience, assuring adequate preparation for residency entry.

D. Dual Designated Programs — training in these programs counts as the 1st year of graduate medical education and as the 1st year of residency. The specified programs are:

a. Pathology
b. Psychiatry
c. Pediatrics
d. OB/GYN
e. Family Practice

NEED NOT REAPPLY FOR CONTINUATION OF TRAINING, if a MOST agreement is signed.

7. It must be emphasized that interns in our flexible programs are functioning under corporate coordinated control, and that the program content must include the desires of the incumbent.

fiscal year, FY-1975, 51 Phase II graduates will complete a year of on-the-job clinical training and will begin to function in their new PA role in hospitals and dispensaries. During FY-1975, 35 selected corpsmen will complete Phase I, the didactic year of PA training; they should complete Phase II in FY-1976. Each year we expect to enroll 100 PA trainees at the Sheppard Air Force Base School in Wichita Falls, Tex., until such time as the demand for qualified PAs throughout the Navy is met.

As you know, the concepts of continuing medical education are being revised. Much of our own current thinking is related to information and guidelines issuing from the Council on Medical Education. (See Figure 2) After 30 Jun 1975, there will be no freestanding internships and the 1st graduate year must be in a continuum of medical education. The term "internship" will be used as long as necessary to insure licensure capability in the various states of the U.S. Following receipt of the M.D. degree, the 1st year of medical education must be accredited by an appropriate residency review committee. The 1st year of a graduate medical education program, for which a graduating medical student applies, must be approved by the director of a certified residency program in the appropriate specialty. Training in dual designated programs counts as the 1st year of graduate medical education and as the 1st year of residency. Accordingly, a medical student will sign a medical officer's service-training (MOST) agreement for placement into such a program at the 1st year (G-1) level. So long as his performance level remains acceptable to the program director, the trainee is offered a continuum of education through the programs. Interns in our flexible programs are functioning under corporate coordinated control, and the program content must be compatible with the desires of the incumbent. This simply means that the flexible programs belong to God and the Navy, and not necessarily the program director to which a trainee's name is attached. In a flexible program the trainee is free, without prejudice to move laterally in any direction he may choose, provided this is acceptable to the subsequent program director involved.

An intelligent approach to administering the flexible programs has been proposed by the staff at Bethesda, and I shall henceforth refer to their useful proposal as "The Bethesda Plan." (See Figure 3)

The Bethesda Plan provides the desired laterality, yet maintains a training content sufficient to ensure a really valid core of organized medical education. It should prove useful to those who are developing program content for the Flexible trainees who will enter our system next year.

FIGURE 3

THE BETHESDA PLAN

Flexible "A" Program Content:

Internal Medicine — 4 months
Emergency Room — 1 month
Intensive Care Unit — 1 month
Pediatrics — 2 months
Electives — 4 months

Acceptable to Anesthesiology, Radiology, Neurology, Internal Medicine, and Dermatology.

Flexible "B" Program Content:

Internal Medicine — 4 months
Emergency Room — 1 month
Intensive Care Unit — 1 month
Electives — 2 months
Surgery — 4 months

Note: Surgery (4 months) encompasses any surgery content, not only General Surgery.

Acceptable to Surgery, ENT, Ophthalmology, Urology, Orthopedics, and Neurosurgery.

Attention is invited to the composite summary of specialty and graduate medical education programs that were offered to graduating medical students for the 1975-1976 training year. (See Appendix, Table 10) The degree to which our subsidy students followed and complied with this system proved very encouraging. In almost every case the applicants precisely indicated the type of program and the hospital for which they were applying. (A former version of this was published previously on page 24 in the June 1974 issue of *U.S. Navy Medicine.*)

If willing to base estimates on certain assumptions or predictions that may, or may not prove accurate, one can project our requirements for given specialties in future years. (See Appendix, Table 11) Using such an approach, for example, we have predicted an increasing requirement for internal medicine (general) specialists: 100 in FY-76, 125 in FY-77, and 150 each in FYs 78, 79, and 80.

Turning our attention now to the debit side of the ledger, let us consider the number of Berry Plan residents who are expected to complete their training in the same subsequent years. It should be noted that our projected overall input from the Berry Plan source of trained specialists drops precipitously from an estimated number of 674 in 1974 to 371 in 1977.

On the basis of Table 11 data a discrepancy between projected requirements for, and available input of, naval medical specialists for future years can be predicted. In the case of internal medicine (general), for example, a requirement of 125 is projected for FY-77, with a total input of 13 trained specialists via the Berry Plan, and 24 specialists emerging from our own graduate training programs. It becomes undeniably clear that we could encounter difficulty in meeting our requirements.

*"Health Care Services for the Navy and Marine Corps"— RADM C.L. Waite, MC, USN:**

Welcome again to SAC Six. It's a great pleasure for me to have the opportunity to speak to you all this morning. You have no idea what it does for our morale to see so many fine people gathered in one place. It makes us want to go back and try even harder.

Now, I'm not going to lead off my particular speech with a joke as the other speakers did, because what I have to say is humorous enough. I get all the nifty jobs in the Bureau — selling iceboxes to Eskimos, things like that — and this is in the same vein.

But what I want to talk to is about our obligation to support naval and Marine operations, and it is an emerging problem which all of us must share the responsibility for solving. We all have an obligation of the highest priority to provide health-care services to the men in our ships at sea and the Marines in the field; and I would remind you pedantically that this entails not only the daily sick call, but routine and special examinations, preventive medicine, upgrading sanitation and habitability, and promoting safety measures to prevent needless injury and loss of life. Additionally and frequently forgotten is the need for a medical officer in support of the operating forces to plan, to evaluate and to train; and not only train and update our own Medical Department personnel, but also we have a distinct obligation to train the troops in the fundamentals of self-help for safeguarding their own health. Doing all of the above, plus being a proficient physician is what makes a naval medical officer unique from any other type of physician.

VADM Custis has stated repeatedly that the medical support to the operational forces has the highest priority in terms of fulfilling our mission, and that this obligation must be recognized and supported by every Navy physician. The Surgeon General has further emphasized that position as evidenced by: the institution of an Assistant Chief of BUMED for medical support

*Assistant Chief for Operational Medical Support, Bureau of Medicine and Surgery Code 5.

RADM C.L. WAITE, MC, USN.—"So, the fleet medical pool and Naval Environmental Health program represent 2 current proposals, but we will need other ideas from you to fulfill all our obligations in the next few years."

to military operations, who shall be nameless; the presence of representatives from the fleet, in attendance for the first time at this SAC meeting; and minimum inroads on fleet staffing.

The office of the Assistant Chief of BUMED for Operational Medical Support, which is now Code 5, encompasses aviation, submarine, surface ship, Fleet Marine Force, and preventive and occupational medicine — in short, all the care and support provided outside of naval hospitals and dispensaries.

In the past the hospital segment of Navy medicine, which most of you represent, has been somewhat protected from the mundane workaday business of caring for the fleet when it is deployed, the major exception being the surgical teams and those designated as Marine Corps augmentees. The major personnel factors which allowed us to develop attractive and retentive graduate training programs were: the drafted doctor, the GMO, and the occasional physician inclined to be a flight surgeon or submarine medical officer. There is no more draft, and the GMO is all but gone from the scene. We will always have a handful of GMOs to man such places as Chinhae, Kamiseya, Diego Garcia, and the like, but this will not be sufficient to support the fleet and the Marine Corps. We have regrouped and reallocated, even to the extent of not manning certain type-command staffs, ship squadrons and flotillas, and many aircraft squadrons and wings.

As an example of what's happening in terms of operational support, let's consider the aviation medical community. In 1972, we had 488 manned flight surgeon billets. Today, 359 billets survive. That's the result of such innovative measures as air station closures, squadron deactivation, and double-hatting wings and squadrons. As of 1 Oct 1974, there are 255 billets filled; as of 1 Dec 1974, it'll be 224; and as of 1 Apr 1975, there will be 214 billets filled. In the training pipeline, we have 9 flight surgeons graduating in Dec 1974, and 17 entering training this month. The point is, and my message to you this morning is: if you have any training disenrollees or nonselects, recruit them for the operating forces, either as flight surgeons or for submarine service, or what have you. We could use them.

At both the Bureau and the fleet levels we are carefully screening the requirements to man ships and to support certain operating forces, in an effort to validate all the requirements and insure effective utilization of medical personnel. You may be assured, therefore, that when somebody does have to go to sea, it will be a validated requirement. All of this is, of course, in addition to the use of nonphysician substitutes such as our Medical Service Corps officers and the independent duty corpsmen, our old standbys. Nevertheless, there are still the larger ships and the Marine forces which do require medical officers. We still need surgeons for aircraft carriers, I would remind you, as well as medical officers for submarines, destroyers, tenders, repair ships, and ships on special missions. Hopefully, most of our contingencies in the next few years can be accommodated with minimal surgical team deployments, and that sort of thing.

How do we accommodate and support two major goals seemingly in conflict: the effective utilization of medical officers, which we've always tried to achieve anyway, and the high priority obligation set by the Surgeon General to support the fleet? Many of you have at least thought about this problem, as we have in the Bureau. Now, two of the alternatives considered and rejected are: first, a separate operational corps of medical officers (that is, separate from the hospital-based corps in both career pattern and assignment), and second, an abandonment of graduate training and the full spectrum of care now provided, with the Navy supporting only active duty requirements. The latter might be called the OMB-HEW concept.

One of the major concepts to emerge that we feel is feasible, credible, and answers the problem in part, is

the fleet medical-pool concept. As of the moment this concept does *not* address Marine Corps operational manning requirements, *only* the fleet. Briefly, the scheme of the fleet medical pool is as follows: medical officers primarily attached to naval regional medical centers will be assigned coverage of particular ships for a period of 2 years. It is essentially a watch, quarter and station bill concept. Five medical officers will be on a watch list to cover the requirements of a specific ship. Once a medical officer has responded to a deployment requirement (up to a 90-day maximum period), his name is moved to the bottom of the list. Individual groups may work out their own period of coverage (to allow for Board exams, meetings, and personal needs). Medical officers so assigned will not be in double jeopardy for surgical team and FMF augmentation assignments, except in the event of major war, of course. All specialists will be eligible, and volunteers are expected. Nonvolunteers will be assigned. An exception will be the anesthesiologist whose expertise should be a part of the surgical team. Individuals, volunteer or otherwise, who are considered liabilities to the region will *not* be acceptable to the fleet medical pool. Credit for this fleet medical pool concept goes to the Code 3 staff, particularly to CAPT Trone.

Two models which are to be implemented this month, the East Coast and the West Coast models are graphically presented in Figure 4. The East Coast model involves four regional medical centers (RMCs): Philadelphia, Bethesda, Camp Lejeune, and Portsmouth, Va.

FIGURE 4

FLEET POOL MODELS (SEP 1974)*

EAST COAST	*WEST COAST*
4 RMCs	3 RMCs
Philadelphia	San Diego
Bethesda	Camp Pendleton
Camp Lejeune	Long Beach
Portsmouth, Va.	
75	50
Medical Officers	Medical Officers
15 Units	10 Units
COMSURFLANT	COMSURFPAC
(CRUDESLANT)	(PHIBPAC)

*(Model to be operative 1 year, and then evaluated)

It involves 75 medical officers assigned to 15 ships in COMSURFLANT, and particularly CRUDESLANT which is the old type command under SURFLANT.

The West Coast model involves: 3 RMCs — San Diego, Pendleton, and Long Beach; 50 medical officers, and; 10 units. That allows 5 physicians to each ship. And in the West Coast model, it's SURFPAC, particularly the PHIBPAC type command. The model is to be operative for a full year; it will then be evaluated and if successful, will subsequently be extended.

Another idea that is just emerging is currently called the Naval Environmental Health Program. Basically this is a concept to develop a career based on Naval Medicine as a specialty, without separating such physicians from the option of clinical practice in the future, or from the rest of the Medical Corps. In fact, the "compleat naval physician" should be both. These officers could fill senior operational billets in the future, complemented by attendance at senior management courses or the Armed Forces staff colleges.

Envisioned as a 4-year training program (See Figure 5), the program would include: the 1st broad-based clinical year in medical-surgical specialties under the aegis of the Chief of Environmental Health Services at, say, 2 hospitals — Portsmouth and San Diego; a 2nd year of education in public health or occupational health leading to a master's degree, or Master of Public Health degree at either Hopkins, Cal., or San Diego; a 3rd year in a subspecialty interest — surface/amphibious/aviation or submarine medicine, global or tropical preventive or occupational medicine — not all of them, but one or the other; and an additional 4th year of practical training at a BUMED field activity, in the same region, in the man's specialty. (See Figure 5)

FIGURE 5

NAVAL ENVIRONMENTAL HEALTH PROGRAM

4-Year Training Program

1st Year: Broad-base clinical year in med/surg specialties, under aegis of Chief of Environmental Health, Portsmouth or San Diego.

2nd Year: Public health or occupational health, leading to a M.S./M.P.H. degree.

3rd Year: Subspecialty interest, surface/amphibious, aviation medicine, submarine medicine, global, preventive medicine or occupational medicine.

4th Year: Additional year at BUMED field activity in same region.

This is essentially CAPT Jack Baker's idea, which has caught on in Code 5 and has gained widespread acceptance among all of the people in the specialties involved. I offer it as a concept only, which still requires further refinement.

So, the fleet medical pool and naval environmental health program represent 2 current proposals, but we will need other ideas from you to fulfill all our obligations in the next few years. As the Surgeon General said this morning, your interest and support is critical to all of our programs because of the esteem in which you all are held, not only throughout the Navy but in your own particular environments. And you are the key not only to the success of our residency-training programs, but also to the effective implementation of the fleet medical pool concept. We earnestly solicit your support in this matter.

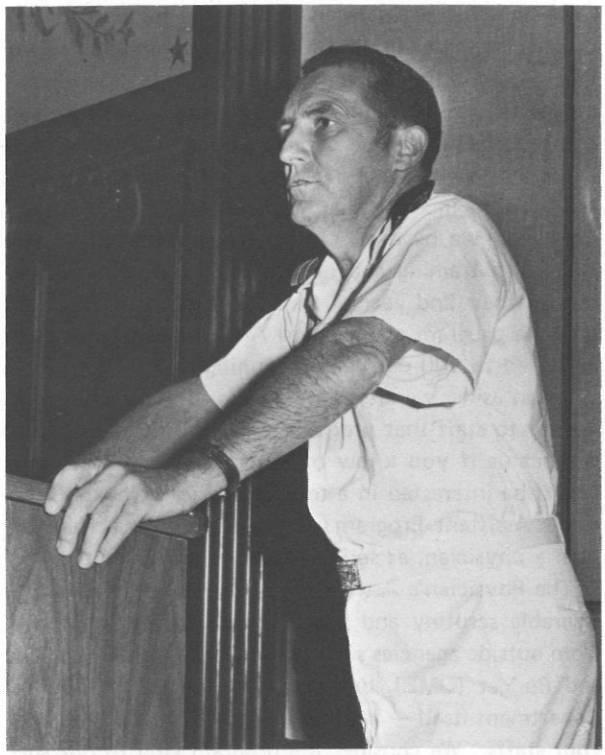
The task is not insurmountable. I cite the career patterns of the Dental Corps, which has met this challenge successfully since the very inception of the Dental Corps. I think we can do the same. My personal impression is that we will need 3 or 4 programs or schemes going for us to do the job. I look forward to hearing your ideas and discussions in the upcoming panel.

"Needs of the Navy Medical Department" —
*CAPT E.B. McMahon, MC, USN:**

The purpose of this presentation is to update you on medical officer requirements, highlight some problem areas, and outline some of the steps being taken to solve those problem areas.

Medical officer requirements can be divided into 3 major categories: fleet and operational unit support; support of graduate medical education, that is, the staffing of our graduate training hospitals, and; the staffing of other health care delivery facilities. A 4th, smaller category should also be considered — administrative or executive medicine.

In the past, with the draft and the draft-driven Berry Plan providing an almost inexhaustible supply of physicians, little long-range planning was done to estimate our requirements for, or utilization of physicians. Such is no longer the case. Our medical officer inputs from the Berry Plan are dropping rather precipitously. At the same time, our scholarship input is coming up. (See Appendix, Table 12) In Jun 1974, 191 scholars graduated from medical school; we anticipate somewhere in the range of 374 graduates next summer. It should be pointed out that these individuals will take



CAPT E.B. MC MAHON, MC, USN.—"From these 2 slides I think it's evident that we can no longer plan, train, and staff as we have in the past. The personnel resources in the same categories simply are not there, nor is it likely that they will ever be there again."

at least 1 year of graduate medical education, and many of them will be among the individuals filling our residency programs in future years.

Even more significant than the drop in the Berry Plan source, I believe, is the fact that our GMO strength has declined even more precipitously. (See Appendix, Table 13) The overall flight surgeon and GMO staffing has dropped from over 1800 in FY-73, to 818 in FY-75. Of that 818, we should point out that some 90 specialists (including internists, obstetrician-gynecologists, pediatricians, and I believe 3-4 general surgeons) are filling billets in purely outpatient facilities, positions which have heretofore been regarded as general medical officer (GMO) billets.

It is evident that we can no longer plan, train, and staff as we have in the past. The personnel resources for the same categories simply are not there, nor is it likely that they will ever be there again. What can we do in an effort to resolve these problems, and continue to meet the mission of the Medical Department? I think several things are being done, or are proposed. All of them need your wholehearted support, and that of your staffs.

*Director, Professional Division, BUMED Code 31.

In an effort to partially relieve the impact of the diminishing number of GMOs in the ambulatory-care area, the numbers of nurse clinicians and physician assistants are being increased. Presently there are on board some 100 nurse clinicians in the fields of pediatrics, obstetrics and gynecology, and ambulatory care. We hope to increase that number to 200 in FY-76. This year, we have 51 physician assistants (PAs) who will finish training and be assigned. Another 33 are now in their 2nd year of training, and the Navy input into the program at Sheppard Air Force Base has been increased to 100 per year, beginning in FY-75.

As an aside, we are actively recruiting for physician faculty to staff that program, and I would urge you to contact us if you know of anyone in your staff who would be interested in a tour as a teacher in the Physician's Assistant Program. There is an urgent need for such a physician, as soon as we can get him there.

The Physician's Assistant Program has received considerable scrutiny and not a little criticism, not only from outside agencies such as the Office of Management and Budget (OMB), but also from within the Medical Department itself — from some of you sitting here, and your staffs. We consider the program vital to our survival. Its success will depend upon the degree to which you support the present concept of health-care delivery, and the extent to which PAs are accepted as valued members of our health-care team, by you, members of your staff, and the residents you train. Patient acceptance of PAs has been extremely positive, not only in the Navy, but in Army and Air Force facilities as well.

Physician training is not intended for the sake of training alone, but must be requirement oriented. Specifically, if a higher-than-needed recruitment and retention rate develops in certain specialties, then we must decrease resident input into such specialties, shifting those training spaces (which are limited) to other specialties where workload and staffing permit adequate training, and where shortages are projected instead of overages.

For years we have relied on the Berry Plan to flesh out the staffs of our graduate training programs. This will no longer be possible after FY-78. Accordingly, we must identify those within our own system who have the capability and the desire to teach, and we must plan their careers appropriately. To that end I would add as a charge to each Specialty Advisory Group, in addition to those charges you have received in writing, that you do your best to collectively identify those people who have the talent, the background, and the desire to become staff members of our graduate training hospitals. This does not necessarily apply to your residents at the present time. Consider people you have trained in the past, colleagues that you're very familiar with, their capabilities and their desires, and direct that input to Code 31.

In addition to our training programs, we must also bear in mind that we have a number of large or small hospitals that are not primarily involved in graduate education, many of which support the operating forces directly or indirectly; and to the extent that this is true, these hospitals must receive priority manning. Frequently, residents have somewhere along the line acquired the idea that, if they are assigned anywhere other than to a graduate training hospital, it's the end of the world. I submit that it's not. I would solicit your support in correcting that impression. A number of us will agree that some of the best experience we had after completing residency training was the opportunity to practice on our own at a nongraduate training hospital, applying some of the principles we had learned and assuming full responsibility for making the ultimate decisions in the management and care of patients, rather than relying upon the gray-haired (or, in some of our cases, not so gray-haired) chief of service.

The 3rd item I would address is fleet support, and Admiral Waite has already discussed this. I should like to reemphasize some of the points that he has made. Traditionally, with the exception of surgeons assigned to aircraft carriers and various surgical teams in certain amphibious ships, fleet medical support has been provided by the assignment of GMOs to particular ships. The abuses, underutilization and complaints generated by this practice are too familiar to be detailed here. But for better or worse, there will no longer be a sufficient number of GMOs to continue this policy. In response to this situation, the pool concept for fleet medical support was developed as outlined by Admiral Waite. It will be tested by means of 2 pilot programs, one on each coast.

Five physicians in the support pool concept will be assigned to each ship, by name. Physicians will know the name of their ship, and the skipper of each ship will know the names of the physicians. A 90-day maximum deployment will be observed. This means that if a ship goes on a 6-month deployment, the deployment will be split between 2 physicians in the pool. We've taken a long, hard look at past and projected operating schedules of our ships; on the average, less than (considerably less, in some cases) 15 months of deployment will occur in a 2-year period of time. To put it another way, the physician would be away from his home hospital and his primary specialty for a maximum of 3 months during the 2 years. At the completion of his 2-year commitment to the pool, the physician could elect to stay in the pool if he so desired, or he could be removed therefrom. The option would be his.

If we are to successfully achieve and maintain an all-volunteer-force Medical Corps, it's imperative that this pool concept succeed. We have looked at all the alternatives to shipboard support, and I think we have even convinced our line counterparts who have insisted for years, "I must have my doctor 12 months a year." They now are convinced that this was not good medical-officer utilization. If we have a relatively stable, all-volunteer force, it would appear that an individual would be liable for pool assignment 3-4 times, perhaps, in the course of a 20-year career.

Support of the operating forces is our major reason for being, and this fact becomes increasingly clear at each encounter we have with all the other agencies — with OMB, with HEW, and with DOD. If we fail to adequately support the operational Navy, then quite literally we will destroy ourselves. Obviously, there will be bugs in this program; that is why we have elected to establish a model on each coast, to work the bugs out of the program.

You might all ask today, "What happens to the chairman of the department in a big teaching program?" In general, I think the departmental chairman will probably be exempt from the pool concept, unless he should volunteer. I would hope that some of them would, not only for the support that it will lend to BUMED and the Navy as a whole, but for the leadership value for junior officers.

I would submit that, if this program for fleet support (which probably requires a maximum 3-month deployment every 4-5 years) should prove so onerous as to be unbearable, then I think that those particular medical officers ought to leave the Navy. They do not realistically perceive their function as naval medical officers, and in an all-volunteer-force, we've got to have NAVAL medical officers.

I would be remiss if I failed to mention the recruiting efforts which are being made. Our scholarship programs are fully subscribed, and we have reviewed the number of graduates emerging this year and next year. This SAC meeting is considering over 900 applications for graduate training. Medical officer recruiting remains the top priority item of VADM Tidd and the Naval Recruiting Command. To date this year, 40 medical officers have been appointed. Eighty-six appointments are pending, and 97 are in process in the field. Interestingly enough, 134 of this total are general medical officers; so they really aren't going to disappear totally and completely.

In conclusion, I believe that the future looks considerably less bleak than it did a year ago at SAC Five; but again, we need the support of all of you, for every single program that has been mentioned this morning.

The following letter from CAPT R.E. Strange, MC, USN was read into the proceedings:*

"To the Psychiatry Program Directors: I'm looking forward to seeing you at the Sixth Annual SAC meeting. It offers a rare opportunity for our program directors to meet and work on the issues, affecting both the training and practice of our specialty in the Navy. Unfortunately, I will have to be absent during the Conference due to other pressing requirements. Since this will not be taking me out of town, however, I will have an opportunity to participate with you.

"There is one major issue that our Psychiatry Committee must address at this Conference. The issue is the definitive recommendation for the composition and organization of the 1st year of postgraduate training in a 4-year psychiatric residency training program. As you know, we discussed this at the APA meeting in Detroit and agreed that a 4-year program, with a broad-based clinical 1st year, would be very appropriate for our training programs. This is consistent with the recent American Board of Psychiatry memorandum which I have enclosed, and is described in 'Training Pattern 2.' 'Training Pattern 1' would still be available for those occasional applicants who have had a satisfactory 1st year of postgraduate training outside of the 4-year training program, after which they could enter our program at the 2nd-year level.

"There is general agreement among all parties concerned that this basic approach is realistic for our Navy needs. There are, however, some complications in regard to organizing the content of that 1st postgraduate year. In our discussions at the APA meeting, we decided that this 1st year should contain a maximum of 6 months of psychiatry, and a minimum of 4 months of medicine. Since that time, however, events and trends in both Navy medicine and the general psychiatric environment have led me to question the wisdom of these guidelines.

"I now believe that we need to limit further the amount of psychiatric rotation occurring during the 1st year, to make it more similar to our old rotating internships. I feel strongly that the amount of psychiatry rotation for the 1st-year resident in this 4-year training program should be limited to no more than 3 months. This recommendation is made only after much thought, discussion, and general soul-searching.

"As I review Navy psychiatry's past and look to its future, I see that its strength has been, and must continue to be a strong and practical medical orientation.

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*Head, Psychiatry Branch of the Professional Division, BUMED Code 313.

As psychiatry struggles to delineate more firmly and maintain its identity, the physician background of the psychiatrist becomes increasingly important. As psychiatrists, I think we have much to lose and little to gain by making the 1st postgraduate year so specialized that the identity and experience of a general physician is lost to the trainee. This is especially important in Navy psychiatry. The basic reason for the existence of uniformed Navy psychiatrists is to support the fleet, and to be available for military contingency utilization.

"For military operations, the psychiatrist must be a physician 1st and a specialist 2nd. In fact, the only way to justify postgraduate medical education in military hospitals is to allow that such education trains physicians specifically for the needs of military medicine, and does so in a way that cannot be duplicated in civilian institutions. In order to support our training programs, we need to be able to say that they are dedicated to training physicians who have all-around medical skills, even though they be specialists. Frankly, I think that the strong medical identity in Navy psychiatry training programs will be an asset in recruiting residents, and in maintaining our quality and prestige.

"These, then, are the reasons for my recommendation that the 1st postgraduate year of our 4-year psychiatry program be truly broad based, with no more than 3 months' actual work on a psychiatry service. This 1st year would, of course, be under the overall supervision of the chief of psychiatry and could be very flexible with respect to rotations and assignments.

"The key issue is simply how much actual time is spent in psychiatry. Our 3 Navy psychiatry residency programs must be consistent in this, and your recommendations will obviously be a major consideration in final policy determination.

"Sincerely, Bob Strange."

PANEL DISCUSSION:

RADM E.J. Rupnik, MC, USN
RADM C.L. Waite, MC, USN
CAPT E.B. McMahon, MC, USN
CAPT W.M. McDermott, MC, USN
CAPT S. Barchet, MC, USN — Moderator.

Q. Under the fleet support pool concept, what control can be exercised over the utilization of assigned medical officers by the line commanders or skippers?

CAPT McMahon: There are checks and balances built into the program. We're going to support about 100 ships in the entire fleet; we have reduced the fleet to a bare minimum at this point.

The major fleet medical officers (RADMs Geib and Laning) are going to monitor this utilization very carefully. Enlisted medical department personnel will function, as they have been doing, on a day-to-day basis. Medical officers will be made available primarily for deployments.

Further monitoring will be done by RADM Waite as the Assistant Chief for Operational Medical Support in BUMED. I think all the BUMED Code 3 staff, certainly Codes 31 and 317 will also be keeping a close eye on it. This program has got to work.

RADM Rupnik: We're only going to use the assigned physicians from the pool for deployment, and we must support the fleet to that extent.

Another important area is the pierside medical support of the fleet. Probably the regional medical COs will have to develop some method — like having a van pierside — to provide daily support to the ships that are pooled there. It shouldn't be an insurmountable problem to utilize medical personnel appropriately in a pierside situation, where doctors aren't given to type commanders to use at will.

Q. Super-specialists at my hospital resist working for half a day in the primary care clinic, with the support of the whole hospital behind them, because they claim to be so specialized that they just can't adequately treat any patient outside their own specialty. How am I going to assign such an officer to the fleet support pool, for 3 months' deployment to the Far East?

RADM Rupnik: RADM Waite had the answer to that. He said we'd take all volunteers, and nonvolunteers will be assigned.

CAPT McMahon: We've got to get away from the concept of the Navy Medical Dept. as a conglomerate of hospitals and dispensaries. Our reason for being is the support of the operational forces.

Under the pool concept, we're talking about a medical officer spending less time in direct support of the fleet over a 20-year career, short of war, then many of you have already spent. I think that's the answer.

Q. What can we tell former Air Force or Army flight surgeons who are interested in coming on active duty in the Navy to fill operational billets?

RADM Waite: Well, "Welcome aboard," for one thing. What would you say about that, Frank?

CAPT Austin: As you know, Navy flight surgeons are required to graduate from a 6-month course that includes 4 academic months in flying. In the past we have taken in a few former Air Force physicians who have never had such a course of instruction in the U.S.

SOCK IT TO US.—Panel members field questions from the floor during the 1st plenary session. (Not shown is the moderator, CAPT S. Barchet.)

Air Force, offering them the option of going through the Navy course if they wish to become designated naval flight surgeons.

Recently, however, we placed a former Air Force flight surgeon in our aerospace medicine residency program, wherein he will really get our 6-month course. We are very flexible, getting quite a few requests, and will look at each case with interest. Many of the U.S. Army flight surgeons were trained in the Navy, of course, and these could readily be qualified as naval flight surgeons.

CAPT McMahon: We've had some embarrassments lately in dealing with applications for recall — not just from flight surgeons, but all physicians. These requests are extremely difficult to justify when previous military performance left something to be desired, as documented in their fitness report jackets from previous service.

So before you promise anybody a recall, advise them that it will depend on their previous military performance, among other factors.

Q. Is it necessary for interns to proceed directly into residency training? Would not 1-2 years of intervening GMO time be a good requirement for most medical officers?

CAPT McDermott: Many would say that proposal has merit. However, with the demise of "internship" and the revised view of the 1st year as a beginning in the continuum of medical education, such a requirement for interim GMO time would appear unattractive to most medical scholars and prospective medical officers approaching our subsidy programs. Nor could there be any absolute guarantee of reentry into a residency program in some future year. There would also be problems in interaction with the civilian sector, were such a policy to be implemented.

RADM Rupnik: The proposal would be ideal, but at this phase of the game I doubt that we will achieve the ideal.

Obviously we will be driving some of our subsidy students into GMO billets for a few years when there just aren't enough training billets to go around, nor will our requirements for certain specialties permit everybody to enter the deferment system of civilian training.

CAPT McDermott: In the "Scholars' Scuttlebutt" column of the Oct 1974 issue of *U.S. Navy Medicine,* there is presented a proposed pathway for the medical student who enters the Navy, finishes 1 year of graduate medical education (GME), then pursues a career pattern into the fleet or some phase of operational medicine, and/or proceeds on to advanced clinical training. We are emphasizing that there are a variety of routes for our young physicians to take, and we hope to develop this concept further in the future.

CAPT Barchet: Yes, the continuum of medical education is not as it has so often been presented in written terms, but is rather in the minds of the beholders. If we get a consistent feeling of what it is that we behold as pathways in the naval continuum, the perspective will spread and take hold in the minds of those whom we bring into the naval service.

RADM Rupnik: On an individual basis we have indeed assigned some medical officers to operational duty following their 1st year of GME, with a promise that they will reenter graduate medical education upon completion of an operational duty tour. But it's been done on an individual basis, based on individual merit. I don't see how we can apply that procedure generally, at this time.

Q. What about our young physicians who fail to make selection for 1st year GME in the Navy, and who therefore acquire that 1st year in civilian hospitals. Why not require them to serve on active duty at the end of that 1st year, and utilize them in GMO billets?

RADM Rupnik: It would depend on whether we are critically short in certain specialties, where we would authorize continuation in a civilian training program to the point of completion, before entering naval service as a trained specialist — a kind of in-service Berry Plan, if you will. But there will be instances in which these criteria will not be met; there will be no other option for assignment after the 1st graduate year, except active naval service as GMOs.

CAPT McDermott: There is an increasingly developed requirement that a physician must have postgraduate training before he can engage in independent, unsupervised practice. Probably within the next 5 years it will not be possible to engage in unsupervised practice unless 2 years of postgraduate training are completed. It would be unwise for us to digress too far from the standards and norms which are being established by powerful and active professional groups.

CAPT Barchet: Trying to estimate the number that would not be selected for continuum in either the Navy or the active-duty-deferment system, I came up with a figure in the neighborhood of 40-60 medical officers who might exercise the option of active naval service as GMOs following completion of their 1st postgraduate year.

We should consider entirely new concepts for our subsidized medical student who comes to us through Public Law 92-426, balancing his needs and desires with our needs and requirements. Hopefully, during his clinical clerkship or any other contact with you, effort will be made to orient and educate him in the Navy milieu and wherewithal, to increase his understanding of realistic options open to him, and how to exercise them.

Q. Will the pool concept include surgeons on carriers, and will any orientation be required for physicians who are assigned to the pool?

RADM Waite: Yes, surgeons on carriers are covered with the pool concept, and will not be placed in double jeopardy for surgical-team deployments, and the like.

We are working on developing some form of orientation which is obviously desirable. It is difficult to insinuate the operational side of medicine in with the preventive medicine side — the things that were either glossed over in medical school or have long since been forgotten — things as prosaic as dishwater temperatures, or immunization requirements for given geographic locations.

There are some very sophisticated things as well, in terms of vibration, heat stress, noise levels, etc. Fleet medical officers receive great backup from preventive medicine units and other experts in addressing some of these problems. And that includes the skilled specialists from the enlisted ranks who render support.

I'm not sure how such orientation should be conducted. The correspondence-course approach doesn't suit me, but there must be some quick refresher course on the current practice of shipboard medicine for physicians who are assigned to the fleet medical pool and face an imminent deployment.

CAPT McMahon: Surgeons are not included in the 2 models that will be implemented this fiscal year. Carriers are not involved in the prototype pool program.

To repeat: 5 medical officers in the pool are assigned to a specific ship for a 2-year period of time. In projected deployments for the models, deployment time will amount to less than 15 months, varying between 10-15 months. The maximum deployment for any medical officer will be 3 months. (If ships are deployed for 6 months, coverage would be split between 2 physicians.) Some deployments will last only 2 months. We cannot set up any system wherein every physician will serve exactly the same number of days, hours, or minutes aboard ship. Some will go for 3 months out of the 2 years, and some will go for 2 months out of the 2 years.

RADM Waite: There's another point to be made here. There must be a list of names to work from, however you arrive at that list. Somebody is going to be at the top of the list. If 6 months go by and there are no deployments, that name remains at the top of the list; there's no down-time on the ships. Similarly, if the fleet medical officer tells us that a particular ship is going into the shipyard for 6 months, that ship will not appear on the list of ships to be covered by medical officers.

Q. What is the attitude of our line colleagues in respect to the pool concept?

CAPT McMahon: I'm not sure. A letter requesting input on the reaction of the type commanders has just gone out from the CNO via the CINCs.

RADM Laning: Informally, I get the opinion that they look to it as a potential solution to a big problem. But we're going to have to make it work, and prove to them that we will indeed support them.

One other thing. When a conflict arises between the skipper of a ship and the CO of a regional medical center, the fleet medical officer will call the decision, in spite of some Medical Corps flag at the center. Now I want everybody here to hear that.

Q. What consideration is being given to ensure that surgeons in a ship are adequately supported by someone with expertise in giving anesthesia?

RADM Waite: That's a good question. Frank, how have you been doing it these past 20 years?

CAPT Austin: We haven't been entirely satisfied with it, but we've tried to have our flight surgeons acquire a modicum of indoctrination in anesthesiology. Anesthesiologists dislike the arrangement; they say we're partially training the men. But we don't have any other choice.

Dental officers often provide us with anesthesia support in an emergency — and they are usually aboard in substantial numbers.

CAPT Tobey: I would like to say that these are not sound solutions to the problem, in my opinion. I regretted to see that the nurse-anesthetist was not mentioned earlier in a discussion of nurse practitioner programs.

RADM Waite: The point is well taken. There's a certain appeal to making the anesthesiologist and surgeon a team. The crunch comes with numbers. We may be forced to reserve the anesthesiologist for surgical team deployment. Hopefully we will not have to deploy 17 teams in the next few years, as we did in the last 2 years. But you never know.

If we could somehow apply the surgeon-anesthesiologist team approach to carrier support, it would be going 1st class for a change.

CAPT Mullen: Why not use the male nurse anesthetist in the carrier?

CAPT McMahon: They're in short supply too. Anesthesia capability in the Navy today is thin.

Q. Could someone address the paradox affecting the medical officer with more than 20 years' service, who can enjoy the dual compensation waiver if he will retire, but is at economic disadvantage when compared with younger physicians under the VIP bill on active duty? Isn't he being recruited out at his zenith of professional value to graduate education?

CAPT McMahon: We haven't had a single chief or assistant chief of service in our graduate training programs retire and apply for waiver of dual compensation, to my knowledge. The scope and nature of the positions are not at all analogous.

RADM Rupnik: I would agree. When I asked Mickey if he was thinking of doing it, he said, "No way."

CAPT McMahon: If this job gets any worse, though, I may reconsider because I could make $8,000 more a year than I make now.

Q. At what point in his career should a medical officer declare his intent to pursue executive medicine, and what is the expected career pattern from medical school graduation to the executive selection board?

CAPT McMahon: The 2-week course in executive medicine which is being given at the Naval School of Health Care Administration (NSHCA) in Bethesda is one way to expose chiefs of service to some basic principles of management. Many of you have had that course.

The point in a career at which one may opt for the executive medicine track will certainly vary with the individual. A commander who accepts a job at BUMED, for example, must be thinking a little that his career could veer that way in the future. From a rank standpoint, such a decision probably emerges somewhere in the CDR — junior CAPT range, for most people.

The Command Selection Board (See Oct 1974 issue of *U.S. Navy Medicine,* p. 35) this year will evaluate records of all year groups from 1950, and senior thereto. It is planned to drop out the top year group, or two each year, and add one new year group per year at the other end. At the point where an officer accepts consideration by the Command Selection Board, he tends to elect the executive career pattern. On the other hand, he can at any time indicate his preference for a clinical career by sending a letter to the Bureau. He can change his mind on this if he so desires.

Of course, CO and director of clinical service billets are not numerous; as an estimate, only around 8-10 such positions will open up in the coming year. Not everyone can have such a billet — there has to be competition and selection to identify the best fitted.

RADM Rupnik: To repeat: anyone who has a change of heart, if in the previous year you had submitted a letter indicating preference for clinical assignment, and in a subsequent year you decide to try the executive route, you will be considered automatically by the Command Selection Board if you fail to resubmit any letter reiterating preference for clinical assignment.

By failing to advise BUMED in writing that you decline consideration by the Command Selection Board, you are telling the detail section that you would accept command assignment, should you be selected for such a position. When physicians turn down the opportunity for a command selection, other corps will have to provide such leadership, i.e., the Nurse and Medical Service (MSC) Corps. The Command Selection Board is accordingly reviewing records of nurse and MSC officers, in addition to those of the Medical and Dental Corps, in order to pluck those Medical Department officers who are most suited for such assignments.

APPENDIX

TABLE 1

NUMBER OF 1974 GRADUATES OF RESIDENCY PROGRAMS
BY SPECIALTIES OR SUBSPECIALTIES

SPECIALTY	*NUMBER OF GRADUATES*
Aerospace Medicine	2
Anesthesiology	20
Dermatology	7
Dermal Histopathology	1
Family Practice	12
Hand Surgery	1
Internal Medicine, and Subspecialties:	37
Cardiovascular Disease	4
Endocrinology and Metabolism	2
Gastroenterology	4
Hematology	5
Pulmonary Diseases	3
Neurology	1
Nuclear Medicine	1
Obstetrics and Gynecology	20
Obstetrics and Gynecology Pathology	1
Occupational Medicine	2
Ophthalmology	9
Orthopedic Surgery	4
Otolaryngology	8
Pathology	5
Forensic Pathology	1
Pediatrics	15
Peripheral Vascular Surgery	1
Plastic Surgery	2
Psychiatry	12
Radiology	16
Surgery	18
Thoracic and Cardiovascular Surgery	3
Urology	6
TOTAL:	223

TABLE 2

SOURCES OF NAVY RESIDENT SELECTEES FOR FY-75

SOURCE	Naval Interns	ACDU	Civilians
Anesthesiology			
Bethesda	2	1	1
Oakland	1	3	
Philadelphia		1	1
Portsmouth, Va.		2	2
San Diego	4	1	1
Anesthesiology Research			
Bethesda		1	
Cardiovascular Disease			
Bethesda		2	
Philadelphia		1	
San Diego		3	
Clinical Immunology & Allergy			
Bethesda		1	
Dermatology			
Bethesda		2	
Philadelphia	2	1	
San Diego	3		1
Endocrinology			
Bethesda		1	
Family Practice			
Camp Pendleton		2	
Charleston	2	3	
Pensacola	2		
Gastroenterology			
Bethesda		1	
Philadelphia		2	
San Diego		1	
Hand Surgery			
San Diego		1	
Hematology/Oncology			
Philadelphia		2	
San Diego		4	
Internal Medicine			
Bethesda	3	4	
Oakland	2	2	
Philadelphia	4	2	3
Portsmouth, Va.		1	
San Diego	7	4	1
Neurology			
Bethesda	1	1	1
Nuclear Medicine			
Bethesda		2	
OB/GYN			
Bethesda		3	
Oakland	1	1	1
Philadelphia	2	2	
Portsmouth, Va.	4	2	
San Diego	4	1	
Gynecologic Endocrinology			
Oakland		1	
Ophthalmology			
Bethesda	3		
Oakland		2	
Philadelphia		3	
San Diego		3	

SOURCE	Naval Interns	ACDU	Civilians
Orthopedic Surgery			
Bethesda		2	
Oakland	2	1	
Philadelphia		2	
Portsmouth, Va.	1	2	
San Diego	2	2	
Otolaryngology			
Bethesda			2
Oakland	1	2	
Philadelphia		2	
San Diego	1	2	
Pathology			
Bethesda		2	1
Portsmouth, Va.			1
San Diego	1		3
Forensic Pathology			
AFIP, Washington, D.C.			1
Pediatrics			
Bethesda	2	1	
Oakland	2	1	
Philadelphia		2	
Portsmouth, Va.	2		2
San Diego	4	1	1
Peripheral Vascular Surgery			
San Diego		1	
Plastic Surgery			
Bethesda		1	
Psychiatry			
Bethesda		3	1
Oakland	1	1	1
Philadelphia	3	1	
Pulmonary Disease			
Bethesda		1	
Portsmouth, Va.		1	
San Diego		1	
Radiology			
Bethesda	2	1	1
Oakland	1		2
Philadelphia	1	1	
San Diego	3	2	1 (+ 1 Army)
Surgery			
Bethesda		2	
Oakland	1	2	
Philadelphia	1	1	
Portsmouth, Va.	2	1	1
San Diego	4	1	1
Thoracic Surgery			
Bethesda		1	
Urology			
Bethesda	1		1
Oakland		1	
Philadelphia			1
Portsmouth, Va.		3	
San Diego	1	1	1
TOTALS:	86	119	33

GRAND TOTAL: 238

TABLE 3

MEDICAL CORPS RESIDENCY/FELLOWSHIP PROGRAMS

A) Number of Residency Programs - 20
B) Number of Fellowship Programs - 14
C) Total Number of Programs - 34

PROGRAM	*LOCATION AND NUMBER OF POSITIONS FILLED*	
	A) RESIDENCY PROGRAMS	
Aerospace Medicine	Pensacola	6
Anesthesiology	Bethesda	4
	Oakland	4
	Philadelphia	3
	Portsmouth, Va.	4
	San Diego	6
Dermatology	Bethesda	2
	Philadelphia	3
	San Diego	4
Family Practice	Camp Pendleton	6
	Charleston	6
	Jacksonville	6
	Pensacola	4
Internal Medicine	Bethesda	6
	Oakland	4
	Philadelphia	6
	Portsmouth, Va.	8
	San Diego	12
Neurology	Bethesda	3
Obstetrics & Gynecology	Bethesda	3
	Oakland	3
	Philadelphia	2
	Portsmouth, Va.	6
	San Diego	4
Occupational Medicine	Other (Outservice and Military)	1
Thoracic & CV Surgery	Bethesda	1
	San Diego	2
Urology	Bethesda	1
	Oakland	1
	Philadelphia	1
	Portsmouth, Va.	2
	San Diego	2
Ophthalmology	Bethesda	3
	Oakland	2
	Philadelphia	2
	San Diego	3
Orthopedic Surgery	Bethesda	2
	Oakland	3
	Philadelphia	2
	Portsmouth, Va.	3
	San Diego	4
Otolaryngology	Bethesda	2
	Oakland	3
	Philadelphia	2
	San Diego	3
Pathology	Bethesda	2
	Oakland	3
	Philadelphia	2
	San Diego	3

PROGRAM	*LOCATION AND NUMBER OF POSITIONS FILLED*	
	A) RESIDENCY PROGRAMS	
Pediatrics	Bethesda	3
	Oakland	3
	Philadelphia	2
	Portsmouth, Va.	5
	San Diego	5
Plastic Surgery	Bethesda	1
Preventive Medicine (General)	Other	1
Psychiatry	Bethesda	4
	Oakland	3
	Philadelphia	4
Radiology	Bethesda	4
	Oakland	3
	Philadelphia	3
	San Diego	7
Surgery	Bethesda	3
	Oakland	3
	Philadelphia	2
	Portsmouth, Va.	4
	San Diego	4
	B) FELLOWSHIP PROGRAMS	
Anesthesiology Research	Bethesda	1
Hand Surgery	San Diego	1
Cardiovascular (CV) Disease	Bethesda	2
	Philadelphia	1
	San Diego	2
Clinical Immunology & Allergy	Bethesda	1
Endocrinology & Metabolism	Bethesda	1
	Oakland	1
Gastroenterology	Bethesda	1
	Philadelphia	2
	San Diego	1
Hematology/Oncology	Bethesda	1
	Philadelphia	2
	San Diego	2
Nephrology	Portsmouth, Va.	1
Pulmonary Diseases	Bethesda	1
	Portsmouth, Va.	1
	San Diego	2
Nuclear Medicine	Bethesda	2
Gynecologic Endocrinology	Oakland	1
Peripheral Vascular Surgery	San Diego	1
Surgical Research	Bethesda	1
Undersea Medicine	Other	3

TABLE 4

INTERN SELECTION BY HOSPITAL AND SPECIALTY FOR THE 1974 - 1975 TRAINING YEAR

HOSPITALS:	*RO*	*R1*	*R2*	*R7*	*R8*	*SM*	*SS*	*PEDS RES*	*OB/GYN*	*PATH RES*	*NP RES*	*FP RES*	*ENT RES*	*TOTAL*
BETHESDA	8	2	2	2	2	4	2	3	2	2	1		1	31
CAMP PENDLETON												6		6
CHARLESTON												6		6
JACKSONVILLE												5		5
OAKLAND	11	2	2	2	1	3	3	1	2	2	1			30
PENSACOLA												4		4
PHILADELPHIA	5	2	4			2	2	1	1		1			18
PORTSMOUTH, VA.	10	5	3		1	6	2	3	4					34
SAN DIEGO	21	2	9	1	2	4	5	3	2	1				50

LEGEND:
Rotating 0 = 4 to 5 months medicine, electives
Rotating 1 = 6 to 8 months medicine, electives
Rotating 2 = 4 to 8 months surgery, 4 to 6 months medicine, electives
Rotating 7 = 4 to 8 months radiology, 4 to 6 months medicine, electives
Rotating 8 = 4 to 8 months anesthesiology, 4 to 6 months medicine, electives
SM (Straight Medicine) = 12 months medicine and subspecialties thereof
SS (Straight Surgery) = 12 months surgery and subspecialties thereof
PEDS RES = Pediatrics residency
OB/GYN = 12 months in OB/GYN
PATH RES = Pathology residency
NP RES = Psychiatry residency
FP RES = Family Practice residency
ENT RES = Otolaryngology residency

NOTE: Off-cycle interns (G-1) will count against 1974 academic year.

TABLE 5

OUTSERVICE PROGRAM GRADUATES

SPECIALTY	*NUMBER OF GRADUATES - 1974*
Adolescent Medicine	1
Cardiovascular Surgery	1
Gynecologic Oncology	1
Infectious Diseases	2
Neonatology	1
Nephrology	2
Neurosurgery	4
Orthopedic Surgery	3
Pediatric Neurology	1
Pediatric Ophthalmology	1
Pediatric Orthopedics	1
Perinatal Biology	1
Radiation Therapy	1
Reproductive-Gynecologic Endocrinology	1
Rheumatology	1
Surgical Oncology	1
Vascular Surgery	1
TOTAL:	24

SPECIALTY	*NUMBER OF GRADUATES - 1975*
Colon and Rectal Surgery	1
Hyperbaric Physiology	1
Neurosurgery	1
Occupational Medicine	1
Ophthalmology-Retina	1
Orthopedic Surgery	1
Pediatric Hematology	1
Pediatric Nephrology	1
Preventive Medicine	2
Public Health	1
Rheumatology	1
Vascular Surgery	1
TOTAL:	13

TABLE 6

RESIDENCY POSITIONS FILLED
AT CIVILIAN INSTITUTIONS, 1974 - 1975

SPECIALTY	*NUMBER OF POSITIONS FILLED*
Cellular Immunology	1
Child Psychiatry	2
Colon and Rectal Surgery	1
Critical Care Medicine	1
Emergency Room Medicine	1
Gynecologic Oncology	1
Hyperbaric Medicine/Neurology	1
Neonatology	1
Neurosurgery	2
Ophthalmology-Retina	1
Otology	1
Pediatric Hematology	1
Pediatric Nephrology	1
Plastic Surgery	1
Preventive Medicine	6
Vascular Surgery	1
TOTAL	23

TABLE 7

SUBSIDY PROGRAMS

PROGRAM	*Present No. of participants*	*Projected No. of participants for next 5 years*	*FUNDING*
1975 (HR-2)	1057	1057	Range of $7,000 to $10,000 per student per year
MOSP	250	220	Range of $15,000 to $17,500 per student per year
SMSP	20	1975 - - 20 1976 - - 5 1978 - - 0	Pay and allowances of a LTJG commensurate with years of service

Clerkship Programs: Number of participants varies.

1975 (HR-2) Clerkships: June - - 200 to 300 participants
July - - 100 to 150 participants
next 10 months - - 30 to 50 participants

MOSP and SMSP Clerkships: Participants are on active duty and may serve in clerkships whenever time permits, on authorization orders.

TABLE 8

NUMBER OF 1974 GRADUATES OF HR-2, MOSP, SMSP, AND 1915 PROGRAMS; NUMBER OF SELECTEES FOR NAVY GRADUATE EDUCATION STARTING IN 1974; AND NUMBER OF GRADUATES ANTICIPATED IN 1975.

PROGRAMS	*NUMBER OF GRADUATES 1974*	*NUMBER OF SELECTEES FOR NAVY GRADUATE EDUCATION-STARTING 1974*
1975 (HR-2)	89	49
MOSP	89	77
SMSP	49	40
1915	36	11
	EXPECTED NUMBER OF GRADUATES–1975	
1975 (HR-2)	315	
MOSP	72	
SMSP	20	
1915	17	

TABLE 9

NURSE PRACTITIONER REQUIREMENTS AND NUMBER TRAINED TO DATE

TYPE OF PROGRAM	*REQUIREMENTS*			*TRAINED TO DATE*
	END FY-1975	*FY-1976*	*FY-1977*	
Pediatric Nurse Practitioners	20	30	30	16
OB/GYN Practitioners	20	20	20	16
Nurse Midwives	3	5	10	0
Family Nurse Practitioners	40	80	120	12
TOTALS:	83	135	180	44

TABLE 10

SPECIALTY AND NUMBERS OF PROGRAMS OFFERED IN GRADUATE MEDICAL EDUCATION TO GRADUATING STUDENTS DURING THE 1975 - 1976 TRAINING YEAR

NAVAL HOSPITAL	ANES C/CD/F	DERM C/CD/F	FAM.P C/CD/F	IN.MED C/CD/F	NEURO C/CD/F	OBGYN C/CD/F	OPHTH C/CD/F	ORTHO-S C/CD/F	OTO C/CD/F	PATH C/CD/F	PEDS C/CD/F	PSYCH C/CD/F	RADIO C/CD/F	SURG C/CD/F	URO C/CD/F	TOT
CAMP PENDLETON, CA	- - -	- - -	8 - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	8
CHARLESTON, SC	- - -	- - -	9 - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	9
JACKSONVILLE, FL	- - -	- - -	9 - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	9
PENSACOLA, FL	- - -	- - -	8 - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	- - -	8
BETHESDA, MD	- - 2	- - 1	- - -	4 4 -	- - 2	3 - -	- - 2	- - 2	- 1 -	3 - -	3 - -	4 - -	- - 2	3 2 -	- - 1	39
OAKLAND, CA	- - 2	- - -	- - -	4 3 -	- - -	3 - -	- - 2	- - 2	- 1 1	2 - -	3 - -	3 - -	- - 2	2 2 -	- - 2	34
PHILADELPHIA, PA	- - 2	- - 2	- - -	6 2 -	- - -	2 - -	- - 2	- 1 1	- - 2	- - -	2 - -	4 - 1	- - 3	2 - -	- - 1	33
PORTSMOUTH, VA	- - 2	- - -	- - -	6 6 -	- - -	6 - -	- - -	- - 3	- - -	2 - -	5 - -	- - -	- - -	4 - -	- - 2	36
SAN DIEGO, CA	- - 4	- - 2	- - -	12 - -	- - -	4 - -	- - 3	- 4 -	- - 3	3 - -	5 - -	- - -	- 3 4	- 4 2	- - 2	55
TOTAL	1 2	5	34	47	2	18	9	1 3	8	1 0	1 8	1 2	1 4	2 1	8	231

KEY:

C = Categorical: 12 months in a single discipline. Programs in Peds, Path, OBGYN, Psychiatry and Family Practice are first-year residencies/internships.

CD = Categorical diversified: at least 6 months in the specialty under which listed plus other rotations.

F = Flexible: at least 4 months in medicine plus other rotations.

— = that particular type of program is not offered at that specific hospital.

SPECIALTY ABBREVIATIONS:

ANES = Anesthesiology, DERM = Dermatology, FAM.P = Family Practice, IN.MED = Internal Medicine, NEURO = Neurology, OBGYN = Obstetrics/Gynecology, OPHTH = Ophthalmology, OTO = Otolaryngology, ORTHO-S = Orthopedic Surgery, PATH = Pathology, PEDS = Pediatrics, PSYCH = Psychiatry, RADIO = Radiology, SURG = Surgery, and URO = Urology.

SPECIAL NOTE: Categorical programs in Peds, Path, OBGYN, Psych, and Family Practice are first-year residencies/internships. Upon reporting for duty, all other trainees will be advised how they can apply for training to continue beyond the first-year level.

TABLE 11

PROJECTED ANNUAL ACCESSION REQUIREMENTS BY SPECIALTY*

PRIMARY CARE	*FY-76*	*FY-77*	*FY-78*	*FY-79*	*FY-80*
Family Practice	50	75	100	100	100
General Int. Med.	100	125	150	150	150
Pediatrics	60	65	70	80	90
Anesthesiology	40	35	30	30	30
Dermatology	7	10	12	10	10
Cardiovascular	14	10	8	8	8
Allergy	3	2	2	2	2
Endocrinology	4	3	3	3	3
Gastroenterology	2	3	4	4	4
Hematology	7	6	5	4	4
Oncology	2	2	2	2	2
Infectious Diseases	2	2	2	2	2
Nephrology	3	3	3	3	3
Pulmonary Diseases	5	4	3	3	3
Neurology	12	16	12	11	10
Neurosurgery	3	2	2	2	2
Nuclear Medicine	4	4	3	3	2
OB/GYN	20	20	12	12	12
GYN Endocrinology	0	1	1	1	1
Occupational Med.	2	2	2	2	2
Ophthalmology	22	11	12	12	12
Orthopedic Surgery	37	35	30	30	30
Otolaryngology	20	20	18	17	17
Pathology	24	20	18	18	18
Plastic Surgery	2	2	2	1	1
Radiology	36	34	30	25	25
General Surgery	32	40	40	35	35
Thoracic Surgery	2	1	2	1	2
Urology	10	6	5	5	5

**Assumptions Upon Which The Above Estimates Are Based:*

1. Stable hospital number and size
2. Minimal GMO resources
3. Retention of all beneficiaries
4. Reduction in CHAMPUS
5. Operational requirements supplied by pools
6. Medical Corps strength of 3800
7. Known/assumed losses as projected in June 1974
8. VIP retention not considered

TABLE 12

MEDICAL CORPS INPUTS

FISCAL YEAR	*DRAFT*	*BERRY PLAN*	*SCHOLARSHIP**
66	361	356	0
67	457	364	0
68	499	617	0
69	31	928	0
70	1	1001	0
71	1	759	0
72	395	768	0
73	15	638	8
74	0	674	36
75	0	581	191
76	0	559	374
77	0	371	414
78	0	193	300

*These students must all take internships and a majority of them will also take residencies, delaying their full service as medical officers by 1 – 5 years.

TABLE 13

DISTRIBUTION OF GENERAL MEDICAL OFFICERS AND FLIGHT SURGEONS

ASSIGNMENT	*FISCAL YEAR*		
	73	*74*	*75*
OPERATIONAL			
Ships	167*	152*	131*
U.S. Marine Corps and Marine Corps Wings	138	99	80
Air (U.S. Navy)	109	103	69
Construction Battalions	13	12	10
HOSPITALS	619	254	64
DISPENSARIES	766	592	456
ARMED FORCES ENTRANCE AND EXAMINATION STATIONS	15	9	8
TOTALS:	1827	1221**	818***

* Includes surgeons assigned to aircraft carriers.

** This includes 90 specialists assigned to outpatient facilities.

*** This includes 108 specialists assigned to outpatient facilities.

1974 SPECIALTY ADVISORY COMMITTEE

Deliberations of Directors of Clinical Services Committee

During both the Specialty Advisory Committees' meeting and the Surgeon General's Conference, numerous subgroups were established to discuss various topics of interest and, where appropriate, to make specific recommendations to the Surgeon General. The deliberations of these committees and their recommendations are now being explored and developed at the Bureau of Medicine and Surgery. Admiral Custis feels that some of the subjects discussed at both these meetings are of interest to the entire Medical Department, and selected committee reports will therefore be published in U.S. NAVY MEDICINE.

The first such report appears below, and it represents the Committee deliberations of the Directors of Clinical Services convened at the SAC Conference. When complete review of the committee recommendations has been completed by the Bureau staff, and the Surgeon General has taken final action on the resulting proposals, all Medical Department activities will be appropriately advised.

I. PRIMARY CARE

Primary care is integral to the practice of all medical specialties and exists in many operative settings. However, for this presentation it is defined as that care which results from an initial patient contact, either in the general adult outpatient clinic or emergency room. This care may be definitive, or provide access to other echelons of the system.

At large medical facilities this function is provided in many different ways and because of variances in patient enrollment, distribution of physicians, plant characteristics and military mission, the actual methodology is best developed locally. One hospital for example no longer staffs the emergency room except with an "on call" physician. Another institution utilizes supervised medical students from a neighboring school.

Some hospitals have benefited by implementing an appointment system in primary-care clinics, such as pediatrics and adult sick call. This is thought not to be feasible in many centers, but where it has been tried, it seems to have sensitized the clientele to exercise discretion and constraint in the use of medical resources. Publicity explaining how to utilize the available facilities is highly desirable, and needs greater emphasis.

Further training and utilization of physician extenders is unanimously encouraged. Screeners, locally developed and armed with written guidelines, are highly effective especially when carefully trained, constructively criticized and empowered with direct-referral rights. Nurse practitioners may be especially valuable and seem to have patient acceptance. Physician Assistants are becoming available in greater numbers and we see a great role for them in such areas as hypertensive, diabetic and weight-control clinics, and even doing physical exams. Unfortunately clinic spaces frequently are not designed to accommodate this help, which must also include Hospital Corps personnel as well as secretaries.

Next we come to the physicians, and despite the anxieties of some senior physicians (in nonclinical fields, or inclined to view their status as somehow threatened), it remains for individual commands to utilize available resources as they must. Primary care is a necessity not just in the Navy, but throughout the nation. If they are to retain the title, all physicians must share the task to the full extent of his or her ability. Certainly if we are to apply the pool concept for staffing operational commitments, all must contribute to the delivery of primary care, and even more. Pathologists and radiologists may be called on to act

as screeners, or to conduct physical exams, thus freeing another physician for primary care.

Malpractice liabilities do not pose a great threat if individual capabilities are not exceeded. Help or consultation is usually readily available.

The use of house staff should also be a matter of local discretion. Since primary care clinic is both the starting point for input to all specialty clinics and the sustainer of training programs, is it not logical to regard the proper conduct of this function as a meaningful educational experience in itself? Training and service must not be confused, but on the other side of the ledger it should be remembered that training programs ultimately sap the capability of a staff to deliver health care at all levels.

The impact on morale does not seem to be as severe as predicted by some. Undoubtedly there is grief, but to quote an old dictum, "Three weeks from now no one will remember we did it any other way."

II. SHORTAGE OF PERSONNEL

Utilization of family practitioner.

Family practice residencies should be established only in those hospitals without other postgraduate medical-training programs, in order to maintain the integrity of the family practice programs and to support their specialty identification.

These hospitals should have large permanent staffs of family practitioners who are actively involved in teaching, as well as other specialists who help with the training programs.

Autonomous departments should be established in any hospitals in which the family practitioners are billeted, in order to ensure equal status with other specialists in that hospital. It is contemplated that, in due course, family practitioners will be able to effectively man all classes of medical facilities, requiring support only from other specialty groups.

Because the family practitioners should not be specifically excluded from the 5 largest naval medical regional centers, ultimately (with an increase in numbers and other priorities fulfilled) they should be considered for placement on the staffs of these regional medical centers. It is imperative that strong family-practice departments be established in our large centers, and that the staff members be permitted to practice their own specialty.

Utilization of paramedical personnel.

Significant points are:

(1) Necessity to expand the utilization agreed upon

(2) Initial experience satisfactory

(3) Surgeon General's guidelines are valuable, but commands must have as much flexibility as possible.

(4) Concern — with increasing numbers, difficulties in monitoring will be intensified and will encroach on "service" time.

(5) Concern — not with what they know, but with what they don't know.

Moonlighting.

Many of the topics which were addressed received considerable attention, with general agreement and concurrence among the Directors of Clinical Services.

The subject of moonlighting, however, proved an exception. There were 10 committee members and there were 10 different concepts. Thus moonlighting became a controversial issue of considerable importance.

There was one single point of agreement, and that was the need for a consistent, singular policy for all physicians in the Navy.*

Some members strongly recommended that moonlighting be abolished: Our Corps needs to show those who find fault with our dedication that they are wrong. One cannot do justice to 2 masters, and no one can be totally loyal to his commitment to Navy medicine if he is actively moonlighting.

Some believe that the increased pay recently legislated for physicians makes it particularly difficult to justify moonlighting, when dependents cannot obtain an appointment for weeks or be seen in primary-care clinics. It was recognized that the abolition of moonlighting will have no appreciable effect on our ability to render more patient care.

Emotionally, some feel strongly that now is the time to pull together and show our resilience, united in total dedication to the care of our eligible patients.

There was a unanimous belief that moonlighting cannot be abolished on legal grounds, and that it is not proper or right to tell our physicians how they can utilize their free time. All agreed that abuse, or obvious inefficiency should be held as strong grounds for removal of the privilege of moonlighting.

The only conclusion that all could accept was that, in the end, performance or lack thereof must be the determining factor upon which the right to moonlight is based, and that collective leadership must be exercised if we are to maintain control of those who feel the need to moonlight.

*A revised, definite BUMED policy on moonlighting is expected to be issued within the next few weeks.

CAPTAIN SELECTEES

MEDICAL

Biehl, Robert F.
Bodenbender, Reinhardt
Brough, James W.
Burkett, Patrick R.
Carson, Thomas E.
Cochran, Robert C.
Colangelo, Eugene J.
Cowherd, Donald W.
Crum, Paul M.
Diamond, Evans
Frankhouser, George V.
Gareis, Frank J.
Hagan, Arthur D.
*Huber, Kitchel H.
Jeffrey, Clyde G., Jr.
Johnsonbaugh, Roger E.
Karnei, Robert F.
Kelly, Robert J.
Kinney, Robert J.
Leisse, Fred C.
Lopez, Domingo A.
Markham, Thomas N.
McLean, Walter L.
Meriwether, Betty A.
O'Halloran, Patrick S.
Ohslund, Ronald K.
O'Reilly, Richard R.
Pasquale, Dominick N., Jr.
Quinn, James J.
Reed, Jerome M.
Roling, Gerald T.
Schwartz, Bradford B.
Smith, Franklin A.
Steimel, Herbert A.
Strickland, George T.
Tyler, Paul E.
Van Valkenburgh, Wood G.
Weber, David M.

*Reservists

DENTAL

Anderson, John W.
Baker, Terrance W.
Besley, Keith W.
Butler, William D.
Chapman, Thom H.
Corderman, Roy C.
Crawford, Benton E.
Daughtry, Max B.
Eastwood, Gerald W.
Gaston, David L.
Gourley, James V.
Greeley, William E.
Harris, Ronald K.
Hart, Gerald L.
Hatrel, Paul P.
Howarth, Hugh C.
Hube, Albert R.
Johnson, James I.
Kellner, Frank H.
Koch, Robert W.

Lusk, Samuel S.
Mason, Billie M.
Maw, Ralph B.
Montgomery, Steve
Moyes, Edmund R.
Murphy, Richard A.
Reisman, Paul J.
Rochford, Philip
Rudolph, Jerome J.
Smith, John M.
Stevens, Mark M.
Stevens, John T.
Tracy, Norman H.
Trusz, Edward J.
Verunac, James J.
Walkowiak, Gene J.
Williams, John P.

MEDICAL SERVICE

Brandon, Daniel A.
Bryant, Eugene M., Jr.
Dennis, J.M.
Heath, Jean L.
Leonard, Russell D.
Schaffner, Leslie J.
Smout, Jay C.
Wimberly, Clyde O.

NURSE

*Colford, Therese V.
Donoghue, Margaret C.
Fine, Rachel A.
Finn, Celine A.
Foley, Alicia M.
Halverson, Ruth E.
Hooker, Doris H.
*Leff, Rae M.
Maynard, Mary E.
Nagy, Bettye G.
Pampush, Ruth G.
Perlow, Marion R.
Peterson, Lee
Proto, Theresa M.
Robinson, Libia G.
Shea, Claire M.
Simmons, Harriet A.
Stewart, Mary G.
Walker, Marilyn J.
Williams, Alice K.

*Reservists

AWARDS AND HONORS

Legion of Merit

RADM Henry A. Sparks, MC, USN

Meritorious Service Medal

RADM George A. Besbekos, DC, USN
CAPT Roger H. Howard, DC, USN
CAPT George E. Vaupel, MC, USN (now retired)

Navy Commendation Medal

CAPT Noel D. Wilkie, DC, USN
LT Paul R. Cowart, MSC, USN

SCHOLARS' SCUTTLEBUTT

IMPRESSIONS OF AN ORIENTATION CRUISE

The first year of medical studies, for me, consisted of successive bouts of basic science memorization between tiresome final-exam periods. Although the prospect of rendering professional service to society was sufficient motivation for the several semesters, I admit to a certain impatience which crept upon me in late winter. Laboring under such circumstances, a Navy invitation to a summer orientation cruise was most welcome. The proposed exchange of Cornell Medical College's concrete skyscraper environment for salt air and sea brightened up school life.

A delay in the issuance of orders prevented reporting to the Fleet Medical Office, CINCLANTFLT, for almost a week. Despite the initial time loss I was outfitted and assigned to a ship within 3 days.

The 1st hours in uniform were awkward. The military formalities to be observed in common situations were unfamiliar to me. A cautious LTJG counseled, "Salute anything that moves."

Wearing the oak leaf and acorn has the immediate effect of impressing upon the wearer the import of medicine, in the eyes of both enlisted men and officers. A jovial master chief who facilitated some early orientation activities related some recent symptoms to me. Mild sensory loss of the right hand was coupled with ipsilateral loss of touch in the lower lip, both symptoms of simultaneous onset, with subsequent recovery of touch to the lip and slower restoration of sensation in the hand. Cerebral angiography had shown no significant abnormalities. The knowledgeable chief took great pleasure in recounting that he had extracted such disparate diagnoses as mild stroke with recovery, to carpal-tunnel syndrome. While a willing party to the man's absorbing sea stories, I avoided adding to his collection of diagnoses, especially on the basis of my first impromptu neurological exam. However, I did explain the anatomical basis for each of the 2 mentioned diagnoses. CDR (CAPT-selectee) C.O. Wimberly, MSC, USN proved an agreeable and efficient program coordinator. I was also called upon to discuss the therapeutic efficacy of vitamin B_6 in gout, a query for which I had no explanation other than a possible placebo effect. All such questions I fielded to the best of my abilities, being careful to emphasize my novice status and to recommend referral to local medical authorities. Applying classroom study in this way was quite a challenge, especially when explanations in lay terms were required.

Embarkation of the USS *Shreveport (LPD-12)* commenced not 2 hours after I arrived aboard her. Also serving as an orientation cruise for 350 Naval Academy midshipmen, it developed that most of the officers (including my advisor, LCDR R.S. Cloward, USN) and many of the petty officers were deeply involved in giving instruction. This worked to my disadvantage from the beginning.

A young and personable line officer, Mr. Cloward drew up a roster of the ship's departments, with a monitor in each, and had intended to follow the prescribed procedure in the Naval Medical Training Institute Curriculum book.

The aim behind the prescribed activities was familiarization with naval occupational hazards. Standing engineroom watches, for example, not only demonstrated the use of the machinery involved, but engendered a greater appreciation for dangerous burns and traumatic injuries incident to explosions. Observing the deck crew in action provided a far greater understanding of the accidents which sometimes occur than reading about them ever could. Similar background was gained by observing the routines of the operations and communications men, whose constant use of electrical apparatus may well lead to inadvertent shock injury. A few days spent with the medical department were enough to acquaint one with the routine problems, such as ingrown toenails and otitis which demand medical attention. Familiarization with shipboard

dangers was accomplished by working in the various departments; the opportunity for first-hand observation and experience was very worthwhile.

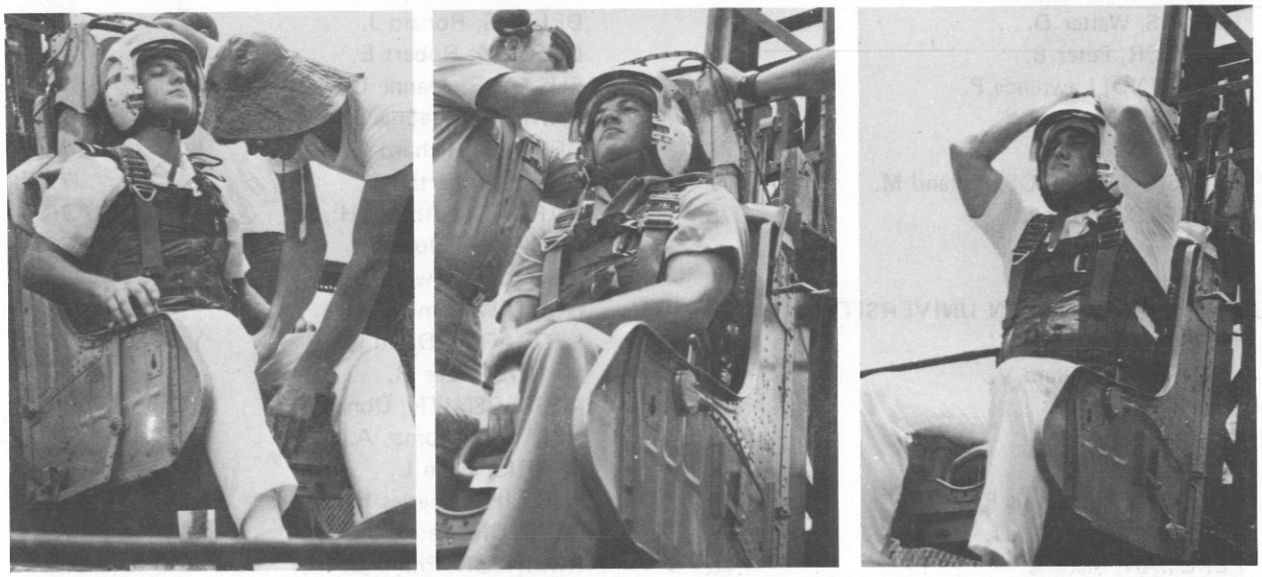
In performing the required activities, I acquired or tried my hand at several skills which a medical student might not expect to develop. Taking over the helm, I had the thrill of steering the 569-foot ship, for a time, in the English Channel. I was able to take a fix of the ship's position with the electronic Omega navigation system, but was unable to master the sextant in the short period allotted. Due to the concurrent instruction of midshipmen, unfortunately, there was no opportunity to participate in other activities as I would have liked.

Unexpected benefits of the cruise were the visits to Rotterdam, Netherlands and to Portsmouth, England. Sightseeing in both locations, and even further inland, I had occasion to befriend some Naval Academy midshipmen and local inhabitants on these trips.

Aside from the more concrete acquisition of knowledge, I developed an awareness of the crew's morale — its subtle elevations and depressions, affected by the approach to or debarkation from foreign ports, respect for officers, food, and numerous other factors. Morale is not such an abstract consideration for the medical officer as it may initially seem, for many accidental injuries may be related to carelessness, horseplay, drugs, or other activities associated with morale.

The cruise was very helpful in my orientation to naval life. Certain aspects of the experience, time wasted on uniform purchase for instance, suggest that some amenities might be covered earlier. If there were an official organization of Medical Corps ensigns at their respective schools, basic information relating to uniforms and military etiquette could be disseminated beforehand, and an avenue for communication between the students and BUMED could be formed. Recruitment of highly qualified applicants could be actively promoted among the junior classmates, especially when a dynamic organization of medical officer fellow students can serve as an honorable example. — ENS Samuel A. Forman, 428 Olin Hall, Cornell University Medical College, 445 East 69th Street, New York, NY 10021.

Ensign Forman, we like your style. You can take a fix of our position and look through our sextant any time. — Ed.



RESERVES SERVE.—Naval Reserve ENSs Gregg S. Parker (left), Theodore F. Smyer (center), and Kenneth W. Kizer (right) spent a summer period of active duty for training in the ejection seat and high-altitude chamber of the Naval Aerospace Medical Institute at Pensacola, Fla., qualifying for jet flights. The three ensigns are Navy medical scholarship students. (Courtesy of PAO, Nav Aerosp and REGMEDCEN Pensacola, Fla.)

STUDENTS PARTICIPATING IN THE 1975 PROGRAM

(partial list, continued)

Medical School Group	*Class of*
UNIVERSITY OF CONNECTICUT	
OSBORNE, Richard G.	'75
WALTER, Richard D.	'76
YALE	
FORDE, Richard J.	'77
GEORGETOWN	
AHBEL, Dorrit E.	'77
BARNES, Roger A.	'75
BAXLEY, Robert S.	'77
BEYER, Gregory L.	'77
BRODINE, Stephenie K.	'77
BROWN, Dennis F.	'75
CASSAMASSIMA, Anthony	'76
ENGLER, Renata J.	'75
HARRIS, Walter D.	'76
PLATZER, Peter B.	'77
SALADINO, Lawrence P.	'75
SIMKOVICH, Joan W.	'77
SMITH, Dennis E.	'76
STASSIONOPOULOS, Yoland M.	'77
STEVENSON, Craig	'75
GEORGE WASHINGTON UNIVERSITY	
CHOISSER, William V.	'75
FANG, Peter J.W.	'77
GIULI, Michael F.	'75
HOLT, Rickie B.	'76
KIMBLETON, Dennis P.	'75
MURPHY, James P., Jr.	'76
PERLMAN, Mark L.	'76
TRUMBULL, Donald	'75
HOWARD	
ARNDT, Stacey D.	'75
CRAGGS, Thomas F. III	'75
CROSLIN, Artis R.	'76

Medical School Group	*Class of*
UNIVERSITY OF FLORIDA	
BLIZIOTES, Matthew M.	'76
COLVIN, Donald B.	'76
CRANE, Jeffrey M.	'77
FORT, Richard A.	'77
HARTWIG, Bruce A.	'75
IACONA, Marie A.	'75
PAULK, Wilford E.	'76
BRICE, David A.	'76
MIAMI	
ANDREWS, Robert C.	'76
ASHBACKER, Jeffrey P.	'75
BOGGESS, Jeffrey P.	'75
BREZINA, Edward J., Jr.	'75
CHAVROS, Donald C., Jr.	'76
CUNNINGHAM, Martin W.	'77
DELANS, Ronald J.	'76
DORLON, Robert E.	'75
EUSTACE, Joanne O.	'76
FARRELL, George J.	'75
GEHRET, Richard G.	'75
GRAY, Roberta	'77
HARDAGE, Robert H., Jr.	'76
HARTMAN, John R.	'76
HOOVER, Lewis D.	'75
HUNT, William M. III	'77
LEONARDI, David P.	'76
MANDEL, Lee R.	'76
MESSERSMITH, Donald P.	'76
NETTER, Thomas A.	'75
PARRIS, Ellen L.	'76
PHILLIPS, Charles E.	'75
PRESTON, Ted L.	'76
ROBINSON, Philip G.	'75
ROMANO, Michael C.	'77
SANCHEZ, Phillip L.	'76
SOPER, David E.	'76
SOWARDS, Dawn L.	'75
TRUCHELUT, Eugene A.	'76
WELLBORN, Roger G.	'76
WELSCH, Robert J.	'77
WERNER, Sheldon L.	'76

Challenges Issued at Surgeon General's Conference

The most immediate challenge facing the Navy Medical Department is to devise efficient programs of health care delivery "acceptable to those who control the purse strings," according to the Honorable James R. Cowan, M.D., Assistant Secretary of Defense for Health and Environment.

Addressing Navy Medical Department executive managers at the biennial Surgeon General's Conference, held 24-26 Sep 1974 at the National Naval Medical Center, Bethesda, Md., Dr. Cowan said that spiraling inflation was forcing Congress to take a hard look at the efficiency and productivity of Government health-care programs. "Outside pressures for economy are so strong that if *we* can't do the job ourselves, someone else will do it for us," Dr. Cowan warned.

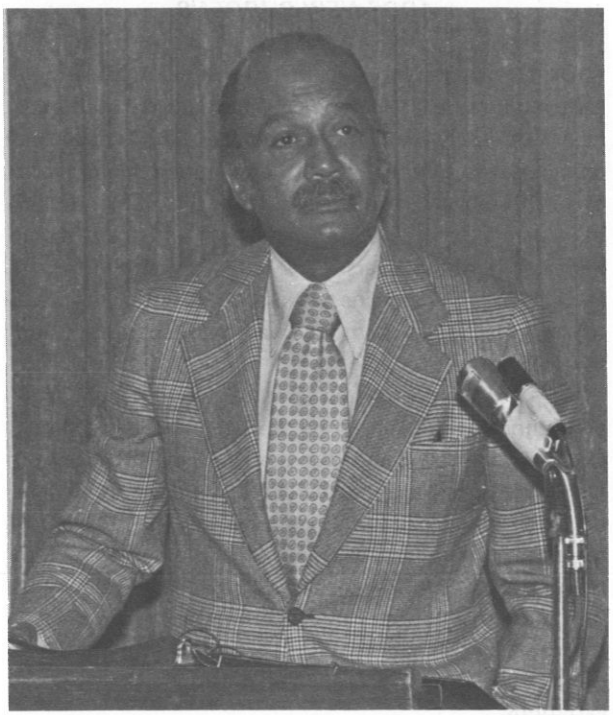
Nearly 200 top Medical Department managers were on hand to hear the Secretary's remarks. Included among the conference participants for the first time were officers of the Dental, Nurse, and Medical Service Corps, who joined their Medical Corps colleagues to discuss the current state of Navy medicine.

Dr. Cowan said programs designed to minimize waste and duplication of services were needed to withstand pressure from "those who feel that all health services should be amalgamated into a single unit." He suggested that the answer to efficient health-care delivery in the military lay somewhere between this "single unit" extreme, and the equally unsatisfactory extreme of "3 entirely separate and competing units without any cooperation or coordination whatsoever."

According to the Secretary, unacceptable levels of productivity and efficiency in military medical facilities can be traced to 4 basic causes:

- A lack of general medical officers
- The improper use of medical facilities
- A highly mobile patient population
- A transient, temporary work force of health care professionals.

However, Dr. Cowan predicted good results would flow from Department of Defense efforts to counter these deficiencies by increasing the number of active-duty military health professionals, developing equitable pay scales, replacing inadequate treatment facilities, and making better use of existing manpower resources.



THE HONORABLE J.R. COWAN, M.D.—"If we can't do the job ourselves, someone else will do it for us."

ATTENTIVE CONFEREE.—The Navy's 1st and only lady admiral, RADM A.B. Duerk, NC, USN, director of Nursing Division, BUMED Code 32.

ADDS NEW BURDENS

Dr. Cowan warned that the all-volunteer force concept would add at least 2 new burdens to military health-care delivery: (1) the average age of active-duty members would rise, with a concomitant higher ratio of health-related problems; and (2) the total number of dependents and retirees needing health care would increase in future years. "We must anticipate a shift in the kind of medicine we are practicing," the Secretary said. "We must move away from acute care and towards chronic care."

As part of a centralized comprehensive health planning concept (a concept he strongly supported while Commissioner of Health for the State of New Jersey), Dr. Cowan reported that his staff was developing productivity standards for various military health care teams to determine the ability of military medicine to respond to the needs of patients. "These standards will provide a means for continued task evaluation," the Secretary explained, "so that changes in patterns of health care will be reflected through productivity variations."

Dr. Cowan also predicted greater regionalization of military health-care facilities on a tri-service basis, citing decreased fragmentation of resources, improved use of highly trained personnel, and more efficient planning and programming of new facilities as benefits to be gained from such action.

Referring to himself as "one sailor who firmly supports and believes in the U.S. Navy," Dr. Cowan called for further close cooperation and coordination between the 3 military services and his office.

PARTNERSHIP NEEDED

VADM Donald L. Custis, MC, USN, Navy Surgeon General, opened his remarks by hailing participation in the conference by senior managers from all of the corps, reflecting the partnership that will distinguish the future of Navy medicine. The success of future programs depends upon the ability of all Medical Department personnel "to function effectively and harmoniously as a truly corporate body of professionals and paraprofessionals," the Surgeon General said.

Heading the list of "good news and bad news" that VADM Custis shared with the conferees was a report on the variable incentive pay (VIP) program. Established to enable the military to compete effectively with the civilian market for physicians, the program authorizes a pay bonus of up to $13,500 a year, with the maximum bonus reserved for certain 0-3 to 0-6 physicians who extend for 4 years.

A number of fine points of the pay situation were clarified by the Surgeon General:

FORUM FOR MANAGERS.—The Surgeon General's Conference was a stimulating forum for the exchange of management information. Above, swapping ideas during a conference break are: LTGEN S. Jaskilka, USMC (left), Deputy Chief of Staff for Manpower, Hq USMC; RADM R.G. Williams, Jr., MC, USN (center), CO, NNMC Bethesda; and VADM D.L. Custis, MC, USN (right), the Navy Surgeon General. The 3 officers were featured speakers during the conference.

THE SURGEON GENERAL'S RECEPTION.—It's always a pleasure to visit dear friends, for example, VADM G. Burkley, MC, USN (Ret.) (center); and CAPT and Mrs. E. Coyl, MC, USN (Ret.).

- The VIP bonus is reduced for short-term agreements, and also decreases with a physician's length of service.
- Officers with initial active-duty obligations incurred through participation in the Berry Plan, the Senior Medical Student Program, the Medical and Osteopathic Student Scholarship Program (MOSP), and the HR-2 Program are disqualified for VIP for the first 4 years, or less of pay-back commitment.
- MOSP and HR-2 students who incur a 7-year active-duty obligation are disqualified for VIP during their first 4 pay-back years; throughout the balance of their pay-back commitment, their incentive pay is limited to $9,000 per year.
- Previously denied, continuation pay (COPAY) is authorized for all qualified primary or initial specialty residents who entered active duty prior to 1 Jun 1974.
- Subspecialty training does not disqualify an active-duty member already receiving VIP from continuing to receive the bonus; however, he may be restricted to the $9,000-per-year rate.
- Qualified medical officers may repay the unearned portion of their COPAY in order to be immediately eligible for VIP.
- COPAY will continue to be authorized for dental officers and all flag officers.
- Officers may voluntarily cancel their VIP contract; however, a penalty pay reduction accompanies the cancellation.
- Professional pay will increase from $100 to $350 per month upon completion of 2 years of active duty.
- COPAY will be affected by base-pay raises; VIP is fixed and not subject to pay raises.

With full VIP options, a new Navy physician with the rank of LT could have an initial income of over $34,000; his pay could reach $47,000 by the time he is a senior CAPT. If the current ceiling on base pay is elevated, the maximum income for an 0-8 is over $52,000.

With the new pay scales, provisions for moonlighting "should, must, and will be tightened," the Surgeon General said. He explained that such controls were demanded by Congressional pressure for maximal use of military physicians, and increasing protests from dependents over cutbacks in health care.

VADM Custis announced that the Chief of Naval Operations had discontinued the Clinical Admiral Program. Senior faculty appointments at the Uniformed Services University of the Health Sciences (USUHS) will provide the best recognition of outstanding clinical, teaching, and research talent in the future, the Surgeon General said. He added that although the new university will have some effect on Medical Department education and training programs, there is no reason to fear unwarranted incursions into service training prerogatives.

Addressing the subject of executive medicine, VADM Custis affirmed that "no medical or dental officer will be assigned outside of a clinical pursujt unless he so desires." Executive medical billets will not exceed 1.5% of the combined Medical and Dental Corps strength. The Surgeon General said that senior officers in all the corps, unless they request otherwise, will be considered by a Command Selection Board which will pluck those officers best qualified for top management and executive leadership roles. (But all those who are qualified will not necessarily receive such an assignment. The billets are limited in number.)

Besides the USUHS and the VIP, the Surgeon General pointed to other promising signs in Navy medicine: blanket waiver of the dual-compensation restriction to allow retired medical officers to serve as civilians in naval medical facilities; full authorized strengths in the Dental, Nurse, Medical Service, and Hospital Corps; reorganization of the Bureau of Medicine and Surgery (BUMED), and increased regionalization of naval medical facilities; ambitious construction programs; and increasing numbers of effective physician extenders. In addition, a systems analyst group with a strong background in health sciences will soon be installed at BUMED.

VADM Custis warned, however, that "Congressional cuts plus further inflation will exact from all of us the most prudent financial planning and management."

THE HONORABLE J.T. MC CULLEN, JR.—"Medical care continues to be a major enticement in achieving an all-volunteer force."

ADM J.L. HOLLOWAY III, USN.—"Programs which have not lived up to expectations must be ruthlessly eliminated."

VADM E.H. TIDD, USN.—"We are in a position now to use only quality input for our subsidy programs."

PERTINENT QUESTIONS POSED

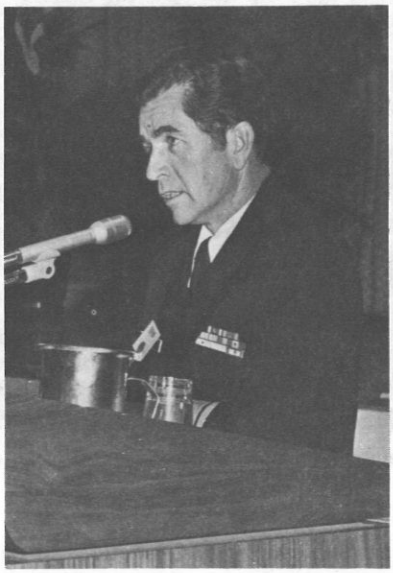
The Honorable J.T. McCullen, Jr., Assistant Secretary of the Navy for Manpower and Reserve Affairs, reaffirmed that Congress is paying close attention to the efficiency and effectiveness of the military medical departments. Among the pertinent questions he posed were: How can we stem the flow of patients from military medical facilities to CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)? How can we get our money's worth from the VIP program? How can we insure a viable, practical physician-patient relationship? Secretary McCullen stressed that medical care continues to be a major enticement in achieving an all-volunteer force, but said that the health-care professional is the hardest member of the Navy team to recruit.

RADM C.L. WAITE.—The Assistant Chief for Operational Medical Support (BUMED Code 5) described the newly organized operational medicine complex.

Shortages of personnel and materiel are also being experienced in other areas of the Navy, ADM J.L. Holloway III, USN, Chief of Naval Operations (CNO), told conference participants. Although the force levels of the U.S. Navy are expected to drop to the lowest level since 1939, there has been no similar drop in naval commitments. This means the Navy must do more with a lot less, ADM Holloway said. In particular, programs which have not lived up to expectations must be ruthlessly eliminated. The CNO said the Navy must continue to put forth a task force in numbers sufficient to fulfill global responsibilities.

LTGEN S. Jaskilka, USMC, deputy chief of staff for manpower, Headquarters, U.S. Marine Corps and VADM E.H. Tidd, USN, commander, Navy Recruiting Command, were also guest speakers during the opening-day morning session.

CAPT J.W. COX, MC, USN.—Discusses purpose and goals of the Naval Health Sciences Education and Training Command, advocating the 3 E's: sustained excellence, equity, and economy.



RADM E.J. RUPNIK, MC, USN.—"Congress is keenly concerned with the cost of military medical operations."

RADM F.F. PALMER, USN.—"NEOCS incorporates a new strategy of career-long training for enlisted naval personnel."

The afternoon session featured addresses by several Medical Department leaders. RADM C.L. Waite, MC, USN, assistant chief for operational medical support, BUMED Code 5, explained the aims and organization of the newly established operational medicine complex; he was followed by CAPT J.W. Cox, MC, USN, who discussed the purpose and goals of the new Naval Health Sciences Education and Training Command, of which he is head. RADM E.J. Rupnik, MC, USN, assistant chief for personnel and professional operations, BUMED Code 3, chairman of the Surgeon General's Conference Committee, then discussed the implications of recent Congressional action, stressing again that Congress is vitally concerned with the effectiveness and efficiency of military medical operations. Particular attention is being given to the staffing levels and workloads of military medical facilities, RADM Rupnik reported.

The director of the Naval Enlisted Occupational Classification System (NEOCS) Implementing Group, RADM F.F. Palmer, USN, from the Bureau of Naval Personnel, gave many of the attendees their first briefing on the revised classification system. According to RADM Palmer, NEOCS incorporates a new strategy of career-long training, as Navy men and women move through career levels from apprentice (E1-E4), to journeyman (E6), to supervisor (E7), to manager (E8-E9). The number of general ratings has been reduced, and new occupational fields have been added. It is anticipated that the medical portion of NEOCS will be implemented in FY-1977 or 1978, RADM Palmer reported.

RADM P. Kaufman, MC, USN, assistant chief for planning and logistics, BUMED Code 4, capped the opening day by urging attendees to develop good functional relationships with their line counterparts. He

RADM P. KAUFMAN, MC, USN.—Reviews budget and facilities planning.

LIVELY WORKSHOP.—High spirits and enthusiasm are evidenced during 1 of 13 workshop sessions conducted on the second day of the conference.

further commented that statistics and communications from the field are of particular importance at this time for planning budget and facility requirements.

Thirteen workshops were conducted on the 2nd day of the conference, during which members of the various corps gained a multidisciplinary perspective of current problems confronting the Medical Department. Workshop chairmen were assisted by advisors who helped direct the discussion, and prepared a final report.

At 3 of the workshops, timely topics of interest to dental personnel were discussed. CAPT R.W. Bruce, DC, USN and his group considered ways in which the Dental Corps could be more cost effective, while CAPT J.D. Enoch, DC, USN led a discussion on the expanded functions of dental auxiliaries. Enhancement of career motivation, retention, and professional satisfaction were the concerns of the group led by CAPT R.J. Leupold, DC, USN. Results and recommendations of these 3 workshops were presented to RADM R.W. Elliott, Jr., DC, USN, assistant chief for dentistry and chief, Dental Division, BUMED Code 6.

Members of the workshop led by CDR B.J. Dietz, MSC, USN discussed problems and benefits of the unit-dose method of delivering medications, recommending that such a system be established within the Navy health care delivery system; however, after studying the feasibility of developing a nonprescription pharmacy formulary for over-the-counter issue of drugs,

RADM R.W. ELLIOTT, JR., DC, USN.—The Assistant Chief for Dentistry and Chief, Dental Division, BUMED (Code 6), received and commented upon recommendations submitted by 3 dental workshops.

CAPT A.J. SCHWAB, MSC, USN.—Director, Medical Service Corps Division (BUMED Code 35) and member of the Surgeon General's Conference Committee.

the group recommended that such a formulary *not* be instituted. Other topics discussed by the group included improved statistical data service, and a study of the effects of an enrollment system on Navy health care delivery.

On the 3rd and final day, RADM-selectee D.E. Brown, MC, USN served as moderator of a plenary session at which reports of the findings of the workshops were presented.

To CAPT W.J. Green, Jr., MSC, USN and his entire staff at the Naval School of Health Care Administration, goes much credit for smooth handling of complex logistics. Coordinator for the Conference Committee, CDR J.C. Thompson, MSC, USN (BUMED Code 2A) provided invaluable support to other members of the Committee, and their assistants.

Shunning easy answers to formidable problems, the medical managers used the conference as a stimulating forum for the exchange of ideas. Ultimately the results of this high-level, high-pressure, think tank are expected to enrich the administrative direction of Medical Department programs.

RADM-selectee D. EARL BROWN, MC, USN.—Co-Chairman of the Surgeon General's Conference Committee, and moderator at plenary session for the presentation of workshop findings.

ERRATA

U.S. Navy Medicine recently reported that "the first extracorporeal renal surgery performed in a military hospital was accomplished . . . at NAVREGMEDCEN Philadelphia on 22 Jul 1974" ("Historic Renal Surgery at NAVREGMEDCEN Philadelphia," *U.S. Navy Medicine* 64[4]:37, Sep 1974).

It has been brought to our attention that 3 procedures requiring extracorporeal reconstruction of renal arteries have been performed at the National Naval Medical Center, Bethesda, Md. On 12 Apr 1973, CAPT William Fouty, MC, USN and CDR Ronald Filo, MC, USNR performed a right renal autotransplantation in conjunction with prosthetic replacement of an abdominal aortic aneurysm. On 5 Oct 1973, CDR William Gee, MC, USN and CDR Filo performed an extracorporeal reconstruction and autotransplantation for atherosclerotic occlusive disease causing renovascular hypertension. Most recently, LCDR Nicholas Feduska, MC, USNR performed extracorporeal repair and autotransplantation for renovascular hypertension due to fibromuscular hyperplasia.

Extracorporeal renal surgery is a significant advancement in vascular surgery, and epitomizes the outstanding surgical care available at naval medical centers. Perhaps other hospitals could be added to the list. We regret having misled our readers by the earlier report, and thank the medical officers who pointed out our error.

Dental Training Committee statistics were incorrectly cited in the "BUMED SITREP" which appeared in *U.S. Navy Medicine* 64(5):34-35, Nov 1974.

The 2nd paragraph should read: "Around 6.9 to 7.0% of the total Dental Corps strength is slated for full-time training. Other selectees for full-time training include: 47 in naval graduate training hospitals (32 general practice residents in dentistry and 15 residents in oral surgery), an additional 9 dental officers selected for residencies in the dental specialties at civilian institutions, and 16 who were picked for postdoctoral fellowships at selected naval installations."

ADDITIONAL CLASS FOR FLIGHT SURGEONS

To counter the critical shortage of Navy flight surgeons, especially among the junior ranks, an additional 6-month training class has been scheduled to begin 7 Apr 1975 at the Naval Aerospace Medical Institute, Pensacola, Fla. The goal is to enroll 5-10 students in this class.

Classes previously scheduled to convene in Jul and Sep 1975 remain valid, with projected goals of enrolling 20 students per class.

Candidates for flight surgeon training should be 38 years of age or younger, and should hold the rank of CDR or below. Waiver of these criteria will be considered only for outstanding candidates having past military service, preferably in naval aviation medicine. There will be few, if any, available assignments for flight surgeons in the rank of CAPT who have had no previous military experience.

Applications are sought from general medical officers, and former flight surgeons who will accept recall to active duty or who may now be serving in other medical specialties. Former flight surgeons trained in the surgical specialties are needed for assignment as senior medical officers aboard aircraft carriers; CDRs are preferred for these assignments, but senior LCDRs and junior CAPTs will be considered.

Medical officers who are otherwise eligible for variable incentive pay can draw the bonus during the course;

the training period in itself does *not* incur an obligation which would affect this bonus. However, candidates are required to serve a 2-year operational assignment following completion of flight surgeon training.

For information on available assignments and career patterns in operational and executive aerospace medicine, contact:

Bureau of Medicine and Surgery (Code 51)
Navy Department
Washington, D.C. 20372
Telephone: Autovon 294-4950
Commercial: (Area Code 202) 254-4950.

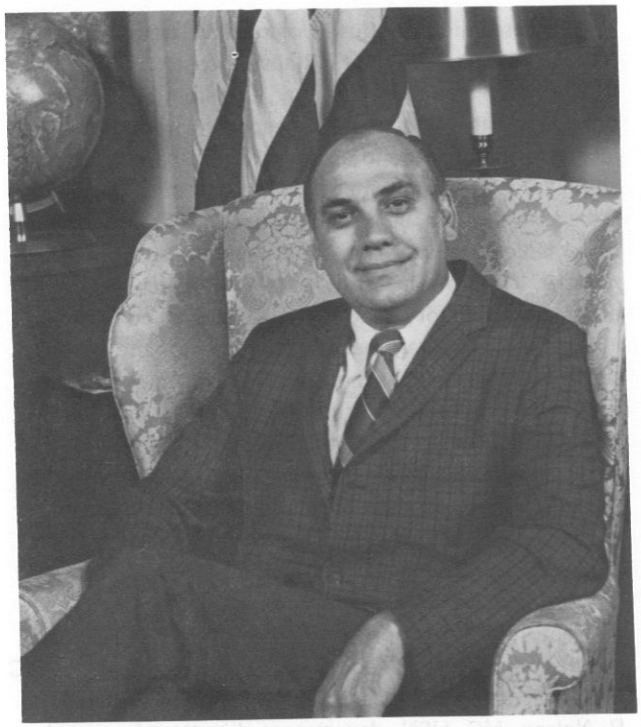
— BUMED Code 51.

CAPT MATARAZZO WELCOMED ABOARD

Joseph D. Matarazzo, Ph.D., a member of the Board of Regents of the Uniformed Services University of the Health Sciences (USUHS), was commissioned a Medical Service Corps captain in the U.S. Naval Reserve on 7 Oct 1974.

A distinguished clinical psychologist, CAPT Matarazzo received his B.A. degree from Brown University in 1948, and his M.S. and Ph.D. degrees from Northwestern University in 1950 and 1952, respectively. He served on active duty with the U.S. Naval Reserve from 1943 to 1947, including a tour of duty in the USS *Manatee*. From 1949 to 1950, he was an extern in clinical psychology at Northwestern Medical School, Chicago. He subsequently became assistant professor of medical psychology at Washington University School of Medicine, St. Louis, Mo., and a research associate in the Department of Psychiatry at Harvard Medical School, Boston, Mass. Since 1957 he has been chairman of the Department of Medical Psychology at the University of Oregon Medical School in Portland, as well as chief of the psychology service at: the University of Oregon Medical School Hospital, Doernbecher Memorial Hospital for Children, Multnomah County Hospital, and Tuberculosis Hospital, Portland.

CAPT Matarazzo is a diplomate in clinical psychology of the American Board of Examiners in Professional Psychology. He has served on the board of directors and board of trustees of a number of local, state, and national organizations, including the National Association for Mental Health, Oregon Mental Health Association, International Council of Psychologists, and the Professional Examination Service of the American Public Health Association. In 1973 he was a member of the National Conference on Levels and Patterns of Professional Training in Psychology, sponsored by the American Psychological Association.



CALL HIM CAPTAIN.—Joseph D. Matarazzo, Ph.D., a member of the Board of Regents, USUHS, was recently commissioned a CAPT in the U.S. Naval Reserve.

A member of many professional societies, CAPT Matarazzo is listed in *Who's Who in America*, *Who's Who in the World*, and *World Who's Who in Science*. In 1962 he received the Hofheimer Prize, an annual research award of the American Psychiatric Association. He is currently psychology editor for *Stedman's Medical Dictionary,* and holds editorial positions with several prestigious publications in the field of psychology. — CAPT M. Museles, MC, USN, executive secretary, Board of Regents, USUHS.

MRS. CAROLYN BLAUVELT HONORED FOR PAPERWORK MANAGEMENT

Mrs. Carolyn T. Blauvelt, a clerk-dictating machine transcriber in the Department of Orthopaedic Surgery, National Naval Medical Center (NNMC), Bethesda, Md., has been honored for her noteworthy accomplishments in paperwork improvement and simplification. Mrs. Blauvelt received a certificate of outstanding achievement from the Association of Records Executives and Administrators at the 10th Annual Federal Paperwork Management Awards Luncheon, held in Washington, D.C., on 23 Oct 1974.

After assuming the duties of medical transcriber at NNMC in Apr 1971, Mrs. Blauvelt began to compile lists of orthopaedic terminology, examinations, abbreviations, and other information needed to transcribe medical reports quickly and accurately. These lists eventually grew into a comprehensive *Orthopaedic Manual for Secretaries,* which became a valuable aid for training new medical transcribers. The manual also provides a number of terms in formats adaptable to the linear programmed history required for use with computers.

With the encouragement of members of the NNMC staff, Mrs. Blauvelt submitted her manual to the American Academy of Orthopaedic Surgeons for review. The executive director of the Academy, Charles Heck, M.D., ascertained that no similar manual had been prepared for use by secretaries or allied health professionals in the field of orthopaedics.

In collaboration with Academy personnel, Mrs. Blauvelt is revising the manual to include new material on fractures, dislocations, and common orthopaedic procedures. She is supported by staff members of the NNMC Department of Orthopaedic Surgery, and by LCDR Fred R. Nelson, MC, USN, department director of research and education.

The *Orthopaedic Manual for Secretaries* will be a useful reference in civilian and military medical facilities where orthopaedic services are available. The manual will also be of use to residents, cast and X-ray technicians, physician assistants, nurses, clinical clerks, attorneys, and others concerned with orthopaedics. — PAO, NNMC, Bethesda, Md.

AUTHOR HONORED.—Mrs. Carolyn Blauvelt discusses her *Orthopaedic Manual for Secretaries* with LCDR Fred Nelson, MC, USN, director of research and education, Department of Orthopaedic Surgery, NNMC, Bethesda, Md. For her work in developing the manual, Mrs. Blauvelt was recently honored by the Association of Records Executives and Administrators at the Federal Paperwork Management Awards Luncheon. (Photo by HM1 Ken Dougherty, USN.)

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IMPRESSIVE CONFEREES.—Participating in the Surgeon General's Conference at NNMC Bethesda, Md., in Sep 1974, are: RADM V.P. Bond, MC, USNR (left foreground); and in 2nd row, from left to right: RADM R.G.W. Williams, Jr., MC, USN, CO, NNMC, Bethesda; RADM A. Callow, MC, USNR; RADM R.C. Laning, MC, USN, Fleet Medical Officer, CINCPACFLT; and RADM D.B. Carmichael, Jr., MC, USNR.